

FORENSIC NURSING EDUCATION IN NORTH AMERICA:  
AN EXPLORATORY STUDY

Dissertation

Submitted to the College of Graduate Studies and Research  
in partial fulfillment of the requirements for the degree of  
Doctor of Philosophy, Department of Educational Administration,  
University of Saskatchewan, Saskatoon, SK, Canada

by

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## ABSTRACT

The *forensic focus* has been a popular career choice and area of study for many of the health science disciplines. Forensic nursing education recently appeared in the curriculum at many colleges and universities. Now more than a decade from when some of the first forensic nursing courses were established, it was timely to explore rather than evaluate this unique specialty that has programs existing at every post-secondary educational level from certificate to doctoral programs.

The purpose of the study was to explore forensic nursing knowledge as a specialty area of study, and factors influencing educational development, as perceived by educators who were instrumental in establishing some of the earliest forensic nursing courses or programs. This predominantly qualitative study involved interviewing a purposive sample of nurse educators from Canada and the United States. Data collection involved an email survey to collect demographic information about the educators and course statistics about the programs they created, in addition to a qualitative, semi-structured telephone interview.

I utilized a thematic analysis to compare the data to literature relevant to the study, which included the historical evolution of forensic nursing along a sequential pattern of specialty development. I drew on my constructivist worldview to understand and interpret the responses. Although exploring forensic nursing provided a starting place for inquiry, the purpose of the research question was not only to describe *what is* but to consider the larger socio-technical, media, and economic forces influencing the

educational development of this forensic specialty and then to link particular experiences into wider generalized and generalizing social relations.

One result of this study was a definition of forensic nursing constructed from the data and compared to earlier definitions in the literature. A further differentiation of forensic nursing determined knowledge that was different from nursing in general, and different from other forensic disciplines, a distinction that has significance for interprofessional education. In addition, it was determined that the unique knowledge content of forensic nursing may be the dual knowledge or dual roles of *care* and *concepts specific to each subspecialty*, for example: care and custody, care and collection of evidence, care and chain of custody, care and court room testimony, or care and crisis intervention.

In the early years of forensic nursing education development, it became evident that more than one positive factor was needed to create and maintain new specialty programs that were not then recognized as future mainstay programs. Therefore, from the constructivist worldview, multiple perspectives exist, and multiple and alternative factors are recognized to have influenced practice, education, and research in any discipline. From a constructivist interpretation to the findings of this study, all factors have relevance as all are needed for specialty programs to be developed and sustained.

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#### DEDICATION

I dedicate this dissertation to the leaders in forensic nursing who contributed to the development of this new specialty through their creation of expanded clinical roles, research and scholarly publications, and educational program development. Many of the participants in this study were some of the early pioneer nurses who forged the advancement of this specialty during the last thirty to forty years. Despite the struggles in the early years, when forensic nursing was not then a recognized area, they embraced the privilege and responsibility of creating a new specialty field of clinical practice and scholarly study. They also celebrated the milestones of creating new roles, founding a professional organization, working to acquire specialty recognition status, and having the standards of practice for forensic nursing approved. Only recently have educational programs been established at every educational level: certification, certificate programs, undergraduate courses, graduate tracts, and doctoral programs. Now, as awareness of the unique specialty area of forensic nursing has heightened and the demand for further forensic educational programs has increased, studies like this will help to record their endeavors in the history of the forensic nursing specialty.

## TABLE OF CONTENTS

PERMISSION TO USE DISSERTATION.....	i
ABSTRACT.....	ii
ACKNOWLEDGEMENTS .....	iv
DEDICATION.....	v
TABLES of CONTENTS .....	vi

### CHAPTER ONE

INTRODUCTION TO FORENSIC NURSING EDUCATION STUDY.....	1
Context of the Study.....	2
Purpose of the Study.....	3
Placement of the Study .....	3
Idea of the Study.....	4
The Research Question(s).....	5
Methodological Approach .....	5
Need for the Study.....	6
Significance of the Study.....	7
Limitations.....	8
Delimitations .....	9
Assumptions of the Study.....	10
Definition of Terms and Abbreviations.....	10
Organization of the Dissertation.....	13

### CHAPTER TWO

REVIEW OF RELEVANT LITERATURE AND RESEARCH.....	15
Purpose of the Literature Review.....	15
Method of Literature Review .....	16
Nursing Science Knowledge .....	17
Nursing Science--Origins & Historical Development.....	17
Nursing as a Professional Discipline.....	17
Nursing Education.....	19
Nursing Specialization.....	20
Requirements Constituting a Specialty .....	21
Patterns of Stages of Specialty Development.....	21
Stage 1, Specialty development in practice setting.....	21
Stage 2, Organized specialty training.....	22
Stage 3, Standardization and emergence of graduate education.....	22
Forensic Nursing Science.....	23
Forensic Science Knowledge .....	24
Forensic Medicine--Origins and Historical Development.....	24
Greece.....	25
England.....	25

China.....	26
Europe.....	26
United States.....	26
Forensic Medicine Education .....	28
Forensic Nurse Investigators/Nurse Coroners)--Origins and Historical Development.	28
Canada.....	28
United States.....	29
Forensic Nurse Investigator--Education .....	29
Clinical Forensic Medicine--Origins and Historical Development.....	30
Police Surgeons--History.....	30
Clinical Forensic Medicine--Education.....	30
Clinical Forensic Nurses (Interpersonal Violence)--History.....	31
Clinical Forensic Nurses--Education and Research.....	32
Forensic Nurse Examiners (Sexual Assault)--Origins and Historical Development.....	32
SANE/SART--Education.....	33
United States.....	33
United Kingdom.....	34
Canada.....	35
SANE--Research .....	36
Forensic Behavioural or Social Sciences Knowledge .....	37
Forensic Psychiatry – Origins and Historical Development.....	37
United Kingdom.....	38
Role of nursing in the U.K.....	41
Summary.....	43
Globally .....	44
United States.....	44
Correctional nursing services in the U.S.....	45
Summary.....	48
Australia.....	48
Canada.....	50
Correctional nursing in Canada.....	51
Forensic psychiatric nursing in Canada.....	52
Summary.....	56
Forensic Psychiatry/Psychology--Education.....	57
Forensic Psychiatric/Correctional Nursing--Education--Clinical Placements.....	57
Formalized Forensic Nursing Education in Colleges and Universities .....	58
Educational Levels .....	60
Certification.....	60
Certificate program.....	60
Graduate degree nursing program.....	61
Doctoral degree nursing program.....	61
Forensic Nursing Specialty.....	62
International Association of Forensic Nurses (IAFN).....	63
IAFN Forensic Nursing Specialty Recognition and Standards of Practice.....	63



IAFN--Mandate and Mission.....	63
Role of IAFN in Development of Policies and Standards of Practice.....	63
Social Movements and Public Policy.....	65
Power of the Media--Forensic Science.....	66
Forensic Nursing Issues.....	67
Discourse in Literature Regarding Forensic Nursing.....	68
Forensic/Forensics Term Discourse.....	68
Forensic.....	68
Forensics.....	68
Forensic Nursing Identity and Conceptualization.....	69
Debates Regarding Forensic Nursing as a Specialty.....	71
Care and/or Custody.....	72
Unique Knowledge.....	73
Research--Forensic Nursing Education .....	76
Need for Forensic Nursing Concepts in the Curriculum.....	76
Forensic Nursing Education--Research to Date.....	83
Online delivery research.....	84
Multidisciplinary/interprofessional training research.....	84
Forensic nursing education--student perspective.....	85
Gaps in the Literature.....	86
Summary of Chapter Two.....	86

### CHAPTER THREE

THE RESEARCH DESIGN AND METHODOLOGY.....	88
The Purpose of the Study Revisited.....	88
The Research Design.....	89
Paradigm.....	89
Constructivism Paradigm.....	90
Choice of Methodological Approach.....	92
Mixed Methods.....	93
Constructivism Interpretivist framework.....	94
Different Types of Constructivism.....	95
Cognitive constructivism.....	95
Social constructivism.....	96
Radical constructivism .....	97
New constructivism.....	98
Rationale for Constructivism.....	98
Rationale for Mixed Methods.....	99
Sample Selection Process.....	100
Sample Selection and Recruitment.....	100
Purposeful sampling.....	101
Criteria for selection of subjects.....	101
Sample size.....	102

Decisions in sample selection.....	102
Participation of subjects.....	102
Costs and benefits to the participants.....	103
Participant schedule.....	103
Setting.....	104
Research Questions.....	104
Data Collection Process .....	104
Phase I – Email Survey of Demographic/ Descriptive Questions.....	105
Email Survey.....	105
Demographic questions.....	106
Descriptive questions.....	106
Descriptive information labeling .....	106
Phase II, Qualitative - Phone Interview.....	107
Semi-Structured Qualitative Questions by Phone Interview.....	107
Forensic nursing questions.....	108
Factors influencing course/program development.....	109
Clarification of questions.....	109
Labeling of qualitative questions and participants.....	110
Transcription of Phone Interviews.....	110
Instruments (Questionnaires).....	111
Email survey (Phase I).....	111
Interview (Phase II).....	112
The Interview from a Constructivist Perspective.....	113
Results of Data Collection Process.....	115
Data Analysis Process.....	115
Descriptive Statistics Analysis .....	116
Content Analysis.....	116
Concept Analysis .....	117
Qualitative Analysis.....	117
Thematic Analysis.....	118
Steps of Thematic Analysis.....	118
Step One, Familiarizing Myself with Data.....	120
Preparing the Data.....	120
Familiarization with the Data.....	121
Field Notes.....	121
Step Two, Generating Initial Codes.....	122
Sorting of Data .....	122
Initiating Databases across Entire Datasets .....	122
Coding.....	124
Step Three, Searching for Themes.....	124
What Counts as a Theme.....	125
Inductive/Deductive Approaches.....	127
Semantic or Latent Themes.....	127

Step Four, Reviewing Themes.....	128
Typologies that Manifested from the Data Analysis.....	130
Forensic Prefix Typology .....	130
Other Typologies .....	131
Tetralogy/Pentalogy.....	131
Step Five, Defining and Naming Themes.....	132
Knowledge Themes.....	132
Step Six, Producing the Report .....	134
Reasons for Choosing Thematic Analysis as the Method of Analysis.....	136
Reasons for Choosing a Constructivism Method of Thematic Analysis .....	136
Limitations and Critique of Constructivist and Qualitative Research.....	137
Interview data as qualitative data collection.....	137
Generalizability.....	138
Researcher's impact on the study.....	139
Over-emphasis on the individual.....	140
Evaluation of the Research.....	141
Validity.....	142
Reliability.....	142
Credibility.....	143
Rigor.....	143
Decision-making processes.....	143
Specific issue to be addressed .....	143
Ethical Considerations.....	144
Ethics Proposal.....	145
Informed Consent .....	145
Confidentiality and Anonymity .....	145
Role of the Researcher.....	146
Summary of Chapter Three .....	148

## CHAPTER FOUR

DATA ANALYSIS of Phase I and Phase II.....	149
Phase Ia Analysis of Email Survey - Educator Demographics (S1-S8) .....	149
S1. Location and Gender.....	149
S2. Highest Level of Education Achieved.....	150
S3. Number of Years of Clinical Experience in Nursing and Forensic Nursing .....	151
S4. Main Focus Area of Nursing and of Forensic Nursing .....	153
S5. Forensic and Forensic Nursing Courses Taken for Credit.....	154
S6. Number of Forensic Courses Developed.....	155
S7. Current Position and Status (Full Time/Part time Sessional/Contract).....	156
S8. Number of Years Experience Teaching Nursing and Forensic Nursing .....	157
Phase Ib. Analysis of Email Survey – Course Statistics (S9-S21).....	158
S9. Type of Educational Institution Where Forensic Course/Program Offered .....	158
S10. Needs Assessment Prior to Course Development.....	159

S11. Educational Level of Forensic Course/Program.....	160
S12. Pre-requisite Required .....	162
S13. Discipline of the Student .....	162
S14. Mode of Delivery.....	163
S15. Clinical Component .....	164
S16. Year Forensic Nursing Course/Program First Offered .....	165
S17. Type of Forensic Courses/Programs Offered (Description and Title).....	167
S18. Elective Options Available in the Nursing Program.....	168
Forensic Nursing Course/Programs Required or Elective.....	169
S19. Number of Semesters a Year Forensic Nursing Courses Offered.....	170
S20. Average Number of Students Registered in Forensic Courses/Programs.....	171
S21. Other Comments? .....	171
Summary Analysis of Phase I, Descriptive Statistics.....	172
Phase Ia Nurse Educator--Demographic Summary .....	173
Phase Ib Course Statistics Summary .....	175
Phase II: Analysis of Qualitative (Telephone) Interview) .....	180
Q1. Forensic Nursing.....	181
Q2. Conceptualized Forensic Nursing in Course/Program .....	185
Q3. Philosophical Base of Forensic Course/Program.....	190
Q4. Philosophical Base of Nursing Program .....	194
Q5. Unique Knowledge of Forensic Nursing .....	194
Q6. How Nurse Educators Gained Knowledge of Forensic Specialty Area.....	198
Q7. Nursing in Title and Concepts to Include?.....	205
Q8. Most Satisfying About Developing and Teaching Forensic Nursing Courses ...	207
Q9. Organizations Foster New Specialty Educational Development.....	212
Q10. Institutions of Higher Learning Have Support New Specialty.....	218
Q11. Factors Influencing Forensic Nursing Specialty Educational Development....	224
(Social, Media, Economic, Technologic and Political)	
11a. Social Factors- -Positive and Negative.....	225
11b. Media Factors- -Positive and Negative .....	229
11c. Economic Factors- -Positive and Negative .....	231
11d. Technology Factors- -Positive and Negative .....	233
11e. Political Factors- -Positive and Negative.....	235
Q12. Reasons Why Educational Development Did Not Occur Sooner? .....	237
Q13. Sustainability Factors of Forensic Nursing Courses/Programs.....	242
Summary Analysis of Phase II--Qualitative Phone Interview .....	245
Thematic Analysis Summary .....	246
Key Finding of Qualitative Interview .....	247
Summary of Chapter Four .....	247

CHAPTER FIVE,	
FINDINGS – KNOWLEDGE THEMES.....	249
Theme 5.10 Knowledge Delineated--Typologies.....	250
Prefix Sub Themes	
5.1A. Typology: Forensic Prefix (adjective) .....	251
5.1B. Typology: Forensics (noun) .....	253
5.1C. Typology: Unique Prefix .....	256
5.1D. Typology: Law/Legal Prefix .....	259
5.1E. Typology: Law/Legal Relationship.....	260
5.1F. Typology: Specialty Prefix .....	262
5.1G. Typology: Emerging/Evolving Prefix .....	265
Forensic Sub Themes	
5.1H. Typology: Forensic Populations.....	267
5.1I. Typology: Forensic Systems/Services .....	271
5.1J. Typology: Forensic Focus.....	274
5.1K. Typology: Forensic Care .....	276
5.1L. Typology: Forensic Roles.....	279
5.1M. Typology: Forensic Subspecialties .....	282
5.1N. Typology: Forensic Disciplines.....	285
5.1O. Typology: Forensic Multidisciplinary.....	289
5.1P. Typology: Forensic Models and Frameworks.....	293
5.1Q. Typology: Forensic Nursing Process (pentalogy) .....	300
5.1R. Typology: Forensic Nursing Paradigm (tetralogy).....	303
5.1S. Typology: Forensic Meta Theory.....	305
Knowledge Themes .....	308
5.20 Theme: Knowledge Needed and Knowledge Concepts to Include .....	309
5.30 Theme: Knowledge Differentiated .....	315
5.40 Theme: Knowledge Dual/Dual Roles (Unique Knowledge).....	323
5.50 Theme: Knowledge Defined/ Definition (Constructed).....	328
5.60 Theme: Knowledge or Educational Development--Influencing Factors .....	333
5.6a Theme: Positive and Negative--Factors Influencing.. .....	333
5.6b Theme: History as a Factor Influencing .....	340
5.6c Theme: Significant Person as a Factor Influencing .....	347
5.70 Summary of Chapter Five .....	350

## CHAPTER SIX

DISCUSSION, IMPLICATIONS, and CONCLUSION .....	352
Choice of Study Topic Revisited .....	352
Choice of Methodology Revisited .....	353
Constructivist Paradigm Approach Revisited .....	354
Discussion.....	354
How and What to Teach .....	355
Is Forensic Nursing a Unique Specialty .....	356
Constituent Parts of Forensic Nursing Knowledge .....	357
Clarity of the Terms: Specialty and Discipline .....	358
Why Some Specialties Advance .....	359
Caring Paradigm .....	362
Unique Knowledge and Dual Knowledge. ....	363
Influence of Partnerships and Affiliations .....	365
Implications for Theory, Practice, Education, and Research .....	366
Implications for Theory .....	367
Implications for Practice.....	369
Implications for Education.....	372
Implications for Research .....	376
Key Findings or Results (Outcomes) of the Study.....	377
Forensic Nursing Knowledge.....	378
Factors Influencing Knowledge or Educational Development .....	379
Conclusion .....	380
Summary of Chapter Six .....	383

## TABLE OF TABLES

Table 3.0 Phases/Steps of Thematic Analysis .....	119
Table 3.1 Step One, Familiarizing Myself with the Data .....	121
Table 3.2 Step Two, Generating Initial Codes .....	123
Table 3.3a Step Three, Searching for Themes .....	125
Table 3.3b Step Three, Searching for Themes .....	126
Table 3.4 Step Four, Reviewing Themes .....	129
Table 3.5 Step Five, Defining and Naming Themes.....	133
Table 3.6 Step Six, Producing the Report.....	135
Table 4.1 Q1. What Forensic Nursing Is.....	182
Table 4.2 Q2. Conceptualization of Forensic Nursing in Educational Programs...	185
Table 4.3 Q3. Philosophical Base of Forensic Course/Program .....	191
Table 4.4 Q4. No table .....	
Table 4.5 Q5. Unique Knowledge of Forensic Nursing.....	195
Table 4.6 Q6. How Educators Gained their Knowledge.....	199
Table 4.7. Q7. No table .....	
Table 4.8. Q8. Most Satisfying/Least Satisfying.....	208

Table 4.9. Q9. Organizations Fostered/Not Fostered .....	213
Table 4.10. Q10. Institutions of Higher Learning Supportive/Not Supportive.....	219
Table 4.11. Q11. Influencing Factors- -Positive and Negative.....	225
Table 4.11a Q11a. Social Factors- -Positive and Negative.....	226
Table 4.11b Q11b. Media Factors--Positive and Negative.....	229
Table 4.11c Q11c. Economic Factors--Positive and Negative.....	231
Table 4.11d Q11d. Technology Factors--Positive and Negative.....	233
Table 4.11e Q11e. Political Factors--Positive and Negative.....	235
Table 4.12. Q12: Reasons Courses Developed and Why Not Sooner.....	238
Table 4.13. Q13: Sustainability Factors--Positive and Negative.....	242
 Table 5.00 Overview of Themes and Findings.....	 249
Theme 5.10 Knowledge Delineated- -Typologies .....	251
Prefix Sub Themes	
Table 5.1A Typology: Forensic Prefix (adjective).....	252
Table 5.1B Typology: Forensics (noun).....	254
Table 5.1C Typology: Unique Prefix.....	256
Table 5.1D Typology: Law/Legal Prefix .....	259
Table 5.1E Typology: Law/Legal Relationship.....	261
Table 5.1F Typology: Specialty Prefix.....	262
Table 5.1G Typology: Emerging/Evolving Prefix .....	266
Forensic Sub Themes	
Table 5.1H Typology: Forensic Populations .....	268
Table 5.1I Typology: Forensic Systems/Services .....	272
Table 5.1J Typology: Forensic Focus .....	275
Table 5.1K Typology: Forensic Care .....	277
Table 5.1L Typology: Forensic Roles .....	280
Table 5.1M Typology: Forensic Subspecialties .....	283
Table 5.1N Typology: Forensic Disciplines.....	285-286
Table 5.1O Typology: Forensic Multidisciplinary.....	289
Table 5.1P Typology: Forensic Models/Frameworks.....	293
Table 5.1Q Typology: Forensic Nursing Process.....	301
Table 5.1R Typology: Forensic Nursing Paradigm.....	304
Table 5.1S Typology: Forensic Meta Theory, Social Justice.....	306
Table 5.2a Theme: Knowledge Needed and Knowledge Concepts to Include .....	309
Table 5.2b Forensic Topics and Modules, 2002.....	313
Table 5.3a Theme: Knowledge Differentiated from Nursing.....	316
Table 5.3b Theme: Knowledge Differentiated from Forensic Disciplines.....	317
Table 5.4. Theme: Knowledge Dual/Dual Roles (Unique Knowledge).....	323
Table 5.5. Theme: Knowledge Defined (Constructed/Created).....	329
Table 5.6a Theme: Positive and Negative- -Factors Influencing.. ..	334
Table 5.6b Theme: History as a Factor Influencing .....	340
Table 5.6c Theme: Significant Person as a Factor Influencing .....	348

## TABLE OF FIGURES

### Figure 4.0 Data Analysis – Descriptive Statistics

Figure 4.S1	Location and Gender .....	150
Figure 4.S2	Highest Level of Education Achieved .....	151
Figure 4.S3	Years of Direct Clinical Experience .....	152
Figure 4.S4	Main Focus Area of Nursing and Forensic Nursing.....	153
Figure 4.S5	Forensic and Forensic Nursing Courses Taken for Credit.....	155
Figure 4.S6	Number of Forensic Courses Developed .....	156
Figure 4.S7	Current Position (Status) .....	157
Figure 4.S8	Years of experience Teaching Nursing and Forensic Nursing...	158
Figure 4.S9	Type of Educational Institution .....	159
Figure 4.S10	Needs Assessment .....	160
Figure 4.S11	Educational Level of Course/Program .....	161
Figure 4.S12	Pre-requisite .....	162
Figure 4.S13	Discipline of Students .....	163
Figure 4.S14	Mode of Delivery .....	164
Figure 4.S15	Clinical Component .....	165
Figure 4.S16	Year Forensic Nursing Course Started .....	166
Figure 4.S17	Type of Forensic Nursing Course Offered.....	167
Figure 4.S18a	Nursing Program Electives.....	169
Figure 4.S18b	Forensic Nursing Course/Program--Elective or Required .....	170
Figure 4.S19	Number of Semesters a Year Forensic Courses Offered .....	171
References.....		385

## APPENDIX A--APPROVAL FORMS

A1	Email Invitation to Participate in Study .....	408
A2	Letter of Invitation and Information about the Study .....	409
A3	Recruitment Information and Consent Form .....	411
A4	Consent for Audio Recorded Phone Interview .....	413
A5	Data Transcript Release Consent Form.....	415
A6	Application for Approval of Research Protocol.....	416
A7	Ethical Permission from the University of Saskatchewan .....	421
	Department of Educational Administration -	
	Acceptance of Comprehensive Examinations.....	421
	Department of Educational Administration -	
	Acceptance of Dissertation Proposal .....	422



## APPENDIX B--PARTICIPANT QUESTIONNAIRES

B1a Email Survey--Descriptive Statistics - Educator (Quantitative) (S1-S8) .....	423
B1b Email Survey--Descriptive Statistics - Course (Quantitative) (S9-S21) .....	425
B2 Semi-Structured Questionnaire - Phone Interview (Qualitative)(Q1-13).....	427

## APPENDIX C--DATABASES TO DATE

C1 Forensic Nursing Educational Programs Globally .....	428
C2 Forensic Nursing Educational Programs--Course Information.....	437
C3 Forensic Nursing General Course--5 Topics .....	445

## APPENDIX D--DATA COLLECTION TABLES

D1 Participant Schedule 2006 (P01-P20) .....	458
D2 Title of Courses Educators Developed (S8) .....	459
D3 Year Forensic Nursing Course First Offered (S18) .....	462
D4 Title of Courses at your Institution (S19) .....	463
D5 Taxonomy of Knowledge Concepts to Include (111) (5.10) .....	465

## APPENDIX E--DATA ANALYSIS TABLES

E1 Phase Ia--Summary of Educators Demographics, S1-10.....	469
E2 Phase Ib--Summary of Course Statistics, S11-S24.....	470
E3 Phase II--Summary of Qualitative Analysis .....	471
E4 Database of Key Words A-Z .....	479
E5 Database of Initial Themes A-Z .....	483

Vita--Brief Biography of the Doctoral Candidate .....	486
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## CHAPTER ONE

### INTRODUCTION TO FORENSIC NURSING EDUCATION STUDY

The term *forensic* has recently appeared as the prefix to many professional disciplines as a focus area of clinical practice and educational development. Forensic nursing, a specialty of nursing, is one of the new specialty or focus areas that has appeared in the last 30 years. Forensic nursing has many subspecialties that deal with the legal aspects of caring for patients who are either victims, offenders, living or deceased. Increased awareness through media attention (e.g., news media and television) may have helped to increase the demand for this educational specialty.

This research was predominantly a qualitative study exploring forensic nursing education from the perception and experiences of nurse educators who had been instrumental in the development of a forensic nursing educational course or program of study. I also collected some descriptive statistics to compare and contrast experience and educational levels in each country (Canada and the United States) where educators gained their knowledge for course content development.

In the literature review, I traced the historical roots of the forensic sciences and the forensic behavioral science specialties. I grounded this study within the larger extant literature relative to this specialty. Social changes, media attention, and advanced technology all seemed to bring about a need for the forensic nursing specialty. Although numerous studies evidenced an educational need for forensic nursing education, it became apparent that educational development of programs did not happen concurrently with role development. Therefore, due to these questions and gaps in the literature with

regard to role and educational development and the paucity of research conducted now that courses are in existence, I believed it was important to conduct this study.

### Context of the Study

Among the specialties in the health science professions in the last thirty years, forensic nursing emerged as one of the most dynamic and fastest growing specialties in today's knowledge society. Nursing students inquired how they could become forensic nurses, and where and how they could acquire forensic nursing education. While forensic nursing courses and programs rapidly appeared in curriculums of many leading colleges and universities, forensic nurse educators also had questions as they developed and taught, often in isolation, some of the first forensic nursing courses. "What content should be included in each course or program of study?" "Are we clear about what the unique knowledge is?" "How do we best organize and disseminate this unique body of knowledge?" and, "Are we conceptualizing forensic nursing consistently nationally and internationally?" (Kent-Wilkinson, 2006). Now that forensic nursing educational programs have been established for over a decade, it was timely to explore the knowledge of this specialty and the factors that have facilitated and impeded educational development.

Forensic nursing as a specialty quickly evolved with little time for the nursing profession to reflect on the process. Practice roles, publications, research, and education all developed simultaneously while the media stimulated the awareness and interest of this specialty among people in and outside the field. Nurse educators began to establish forensic nursing educational courses with little time to ponder whether or not there was

consistency in the field as to its ideological base, and they did so without a template as a framework to follow or to critique (Kent-Wilkinson, 2006).

The recognition of forensic nursing specialty status by the American Nurse's Association (ANA) in 1995 required that the specialty define and explicate its major conceptual base in terms of definition, and scope and standards of practice (American Nurses Association, 1995). The challenge of integrating into an educational curriculum, an epistemology that explained the theoretical foundations of this newly formed specialty was taken up by nurse leaders in the field.

#### *Purpose of the Study*

The purpose of the study was to explore forensic nursing knowledge as a specialty area of study and factors influencing educational development, as perceived by educators who were instrumental in writing and teaching the initial forensic nursing courses or programs. The intent was that this study be an exploratory descriptive study of some of the seminal forensic courses/programs now in existence, not an evaluative study of the course content. The aim in this study was not to judge but simply to determine a collective understanding to what the concepts and conceptualizations were. .

#### *Placement of the Study*

Specialty areas ultimately evolve to meet the unique or increased needs or demands of society. Social movements, public policies, and advances in technology have influenced the development and delivery of new specialty educational endeavors. Inadequate health care standards, inmate's lawsuits, public inquires, and the awareness

and attention to victim and inmate rights have been the impetus for the evolution of many of the subspecialties of forensic nursing.

This research on the knowledge of forensic nursing, and factors influencing the educational development of the specialty began to add to the limited educational research conducted to date on forensic nursing education. By identifying the studies since the 1970s, on the need for forensic nursing education, I positioned this study through the literature review within the timeline of initial educational research conducted on forensic nursing programs.

After completing the data analysis in this study on forensic nursing education, I compared the key participants' responses (data extracts) from each question to the literature. By integrating the findings with similar issues and studies reported I positioned the study within the knowledge of the nursing discipline and educational specialties.

#### *Idea for this Study*

My interest in the conceptual issues of forensic nursing education evolved from the opportunity I had to write and teach forensic nursing courses since the mid 1990s. While it was a privilege to construct some of the initial forensic nursing courses, it was also a responsibility. Without a template of previous forensic nursing courses in existence, it was a challenge to decipher what knowledge elements to include and how to frame the course conceptually. Although I had practiced nursing in different forensic areas, what was most difficult about the process of developing the courses was conceptualizing the theoretical framework and deciding on the units of study. Because there was not a general course yet available on forensic nursing, my questions to myself

at the time were: What ideologies guide forensic nursing, What concepts need to be included, and How do I articulate how forensic nursing courses are different from other nursing courses?

By the time I embarked on my doctoral research there were a number of forensic nursing programs established. I believed it would be timely and useful to study the established programs. I wanted to investigate the research questions I had struggled with when I was developing forensic courses. These questions were triggered by issues manifested over a period of years. I wanted to ask, for example, how other educators determined what the unique knowledge of forensic nursing was, and if and how organizations fostered this new specialty development. This study provided me with the opportunity to ask other educators to reflect on what socio/economic and political factors influenced their educational institutions to establish programs in forensic nursing.

### The Research Questions

In this study I explored forensic nursing knowledge from the perspective of forensic nurse educators who developed and taught some of the earliest educational programs:

- What is forensic nursing knowledge as a specialty area of study?
- What factors influenced the development of forensic nursing education?

### *Methodological Approach*

My belief was that a mixed methodology would best answer my research questions. Along with the process of doing this qualitative study, I collected descriptive statistics to gain an understanding of the educator's personal and professional

demographics and descriptive information about the courses they created. Background data about the participants proved to be important as to how they perceived the ideological underpinnings of forensic nursing.

To answer the research questions, I selected an exploratory approach drawing from a constructivist paradigm. The process included both a thematic analysis of the literature, and a constructivist approach to understanding and interpreting the interviews of educators who had a direct role in the educational development of this specialty. A thematic analysis of interview data was an appropriate method for generating explanations of phenomena that were directly relevant for this focus of study. I needed this kind of research to help to answer questions about why social processes worked the way they did, and to describe and explain experiences of the participants.

#### Need for the Study

Creswell (1998) believed the strongest and most scholarly rationale for a study, follows from “a documented need in the literature for increased understanding and dialogue about an issue” (p. 94). Because a decade has passed since some of the first programs were developed, I believed it was time to do an exploratory study, rather than an evaluative study on forensic nursing education. There was a need to study the unique, constituent aspects of the knowledge of forensic nursing and what factors had influenced this growing specialty development to where forensic nursing now has its own certificate, graduate, and doctoral nursing programs. Also there had been little research done on the pedagogical dimensions of forensic nursing.

The rationale for the study revolved around the paucity of research undertaken to identify the constituent parts of this professional practice. How forensic nursing education is conceptualized as to its foundational philosophical underpinnings may have a theoretical relevance to nursing and to university administration given the trend toward interprofessional education.

The need for this study was also evident by the debate in the literature around whether or not forensic nursing is a unique specialty, or whether generalist principles of professional working practices are merely being applied to a specific patient population; and if there is a unique body of knowledge known as *forensic* (Mason & Carton, 2002).

Mason (2002) noted that nursing has not established a monopoly on the forensic specialty, nor should they, because many other health care professionals also have recognized specialization in the forensic area, for example, forensic psychiatry, forensic psychology, or forensic social work. “The quest for forensic nurses, as it is for the other forensic disciplines, is to establish their unique knowledge for working with their patient groups” (p. 512). There is a need for forensic nursing to articulate its unique knowledge different from and common to other forensic professional disciplines, and as well be able to communicate what makes forensic nursing different from nursing in general.

### *Significance of the Study*

Many universities are implementing specialized programs and are developing an educational niche for themselves by focusing on specific areas of study (Portugal, 2006). Universities and colleges contemplating the development of future forensic educational programs in any discipline may benefit from the information gathered in this mixed



methods study. This study may serve not only to advance the specialty of forensic nursing, but also may challenge forensic nurses to articulate clearly the theoretical foundations of forensic nursing.

This study provided information on the unique aspects of forensic nursing knowledge, on the concepts to include, and on issues that have influenced program development, which may all provide a base for educational standardization. Why some specialties evolve to where there is the need and the demand for their own graduate and doctoral programs, and why some do not, is a question of interest to educational research in any discipline. It is of particular interest now as the trend for interprofessional and intersectoral collaborations for programs increases. It is even more necessary to demarcate the roles and specific knowledge of each discipline. In addition, this study provided the opportunity to explore the significance of the educator role and contribution to the evolution and the advancement of a specialty.

#### *Limitations*

For the purpose of this study *limitation* is defined as a restriction, a disadvantage or weakness. In comparison, *delimitation* is defined as a limit or boundary (Thesaurus, 2007).

What must be considered as a limitation of this study may have been my impact on the study by my role as researcher. As the researcher, as Merriam (2002) stated, “I was the primary instrument for data collection and data analysis” (p. 5). Due to my experience of writing and teaching many forensic nursing courses, I naturally had my own perceptions about the process. I admit many times I had a difficult time separating

my role as researcher from that of participant. In the analysis process I had to guard against: prematurely forming themes before generating them through the data collecting and analysis process; dominating the interviews; being constrained by preformulated or leading questions; and, seeking generalizability of the sample.

Morse (1996) noted, “Limitations exist with the degree of generalizability” (p. 149). In this study, generalizability may be an issue due to the small sample size of established forensic nursing programs. Because the development of forensic nursing educational courses was relatively new, my sample included only 17 educators. However, sample size was a good representation, given that until 2005 there were only 20 to 25 established programs in existence.

### *Delimitations*

My study was delimited to forensic nursing education, although other health science and behavioral health science disciplines also have forensic courses. Some other forensic specialties include: forensic medicine/science, forensic psychiatry, forensic psychology, forensic social work, and forensic entomology. My study was delimited to Canada and to the United States due to the geographical convenience of the purposeful sample in the timeframe of this doctoral dissertation.

An important delimitation was that the research was an exploratory descriptive study of some of the seminal forensic courses/programs now in existence; it was not an evaluative study of the course content. This point was made clear to participants on the consent form. The purpose of the study was not to judge, but simply to determine or understand what the concepts and conceptualizations were.

Participants in the forensic nursing education study needed to meet two common criteria: (a) they had to have written/developed at least one forensic nursing course, and (b) taught at least one forensic nursing course. The study was also delimited to responses collected by email and telephone interviews rather than face-to-face contact.

### *Assumptions of the Study*

The views of the participants about forensic nursing education are examined in the context of their geographic locations, educational and clinical backgrounds, ideologies that their universities support, and their own theoretical opinions. Therefore, the assumptions of this study were that each educator structured or constructed forensic courses according to his/her experiences and different understanding of the literature, the work of others, and other influencing factors. In November, 2005, following ethical approval of my research proposal (Appendix A7), I used a constructivist qualitative approach to do an exploratory study of forensic nursing education. I received no funds to conduct that research.

### *Definition of Terms and Abbreviations*

What is a forensic nurse and what constitutes forensic nursing as a specialty are questions asked not only by the general public, but also by practicing nurses who are looking for a career change. Often the public has preconceived notions of the forensic careers, due to what they see in the media. Definitions and abbreviations of terms that were used in this dissertation are provided here. (single spaced to facilitate readability)

*Construct.* Build or assemble something by putting together separate parts in an ordered way; to create in the mind, to create something, such as a theory, as a result of systematic thought systematically. (Encarta dictionary, 2007)

*Forensic.* (adjective) Forensic as a term has been defined as “pertaining to the law”. The term *forensic* originates from the Latin word *forensis* meaning public forum or “of the forum” where the law courts of ancient Rome were held. The function of the term is as an adjective (Merriam-Webster’s Online Dictionary, 2004). Today, forensic refers to the application of scientific principles and practices to the adversary process where specialty knowledgeable scientists play a role. (American Board of Forensic Psychology, 2007)

*Forensics.* Forensic science (often shortened to forensics) is the application of a broad spectrum of sciences to answer questions of interest to the legal system. This may be in relation to a crime or to a civil action. The use of the term “forensics” in place of “forensic science” could be considered incorrect; the term “forensic” is effectively a synonym for “legal” or “related to courts” (from Latin, it means “before the forum”). However, it is now so closely associated with the scientific field that many dictionaries include the meaning that equates the word “forensics” with “forensic science”. (Wikipedia, 2007c; 2007d)

*Forensic nursing.* Forensic nursing is an umbrella term that encompasses diverse subspecialties of forensic nursing who practice nursing, by providing care to victims of violent crime, perpetrators of criminal acts, or care of the deceased, and their families. A definition by Lynch in 1991, adopted by the International Association of Forensic Nurses (IAFN) stated forensic nursing was the application of the forensic aspects of health care combined with the biopsychosocial education of the registered nurse in the scientific investigation and treatment of trauma, and or death of victims and perpetrators of violence, criminal activity, and traumatic accidents within the clinical or community institution. (IAFN, 1993a)

*Forensic nursing subspecialties.* Nurses who are death investigators, sexual assault nurse examiners (SANEs), interpersonal violence nurse clinicians, forensic emergency nurse specialists, correctional or prison nurses, forensic psychiatric nurses, forensic community mental health nurses, forensic pediatric or geriatric nurses, or legal nurse consultants all fall within this field of practice. (IAFN, 1993b)

*Forensic science.* Forensic science (often shortened to forensics) is the application of a broad spectrum of sciences to answer questions of interest to the legal system. This may be in relation to a crime or to a civil action. (Wikipedia, 2007c)

*Forensic medicine.* Legal medicine or forensic medicine is the science concerned with the application of medical knowledge to certain branches of the law, both civic and criminal; the branch of medicine that has a specifically legal purpose, for example, establishing the cause of a death. (Encarta dictionary, 2007)

*Generalist.* A registered nurse prepared to practice safely and effectively along the continuum of care in situations of health and illness across the person's life cycle. (Saskatchewan Registered Nurses Association [SRNA], 2007)

*Injury.* "The term 'injuries' has, by and large, replaced 'accidents' in the prevention literature to highlight the health impact on the person and the existence of preventable factors in their causation (Waldram, Herring, & Young, 2006, p. 85).

*Knowledge themes.* A theme is a distinct and unifying idea. The knowledge themes identified in this study were: knowledge delineation, knowledge differentiated, knowledge demarcated, knowledge definition, knowledge needed, dual knowledge and unique knowledge.

*Delineation.* Description, definition.

*Demarcation.* Separation.

*Differentiation.* Differential, degree of difference.

*Nursing paradigm.* The nursing paradigm has been widely identified as the four areas of: person, health, environment, and nursing. The nursing paradigm in this study was applied to the specialty of forensic nursing through selected data responses from the interview questions.

*Nursing process.* The nursing process was originally an adapted form of problem solving and classified as a deductive theory (Wikipedia, 2007g). The nursing process has been widely identified as the five steps of assessment, nursing diagnosis, planning, intervention, and evaluation. The nursing process was applied to the specialty of forensic nursing in this study by comparing the steps to the scientific process and the legal process and through selected data responses from the interview questions.

*Pentalogy.* Group of five related concepts (e.g., nursing process: assessment, nursing diagnosis, planning, intervention, evaluation).

*Specialist.* A registered nurse who practices in a specific area and has gained experience and expertise in that focus area. (SRNA, 2007)

*Specialty.* The Canadian Nurses Association defines specialty as "a specified defined area of clinical and functional nursing with a narrowed, in-depth focus, necessary for the safe delivery of the full range of services required in that area of nursing. (Canadian Nurses Association [CNA], 1982, p. 25)

*Taxonomy.* Classification.

*Tetralogy.* Group of four related concepts (eg., nursing paradigm: person, health,

environment and nursing)

*Typology.* A descriptor or typology is the study or systematic classification of types, the study of systematic classification of types, created from the initial data of Descriptors.

#### *Latin Terms*

- *actus rea*: criminal act
- *ceteris paribus*: other things being equal
- *custom placitorum coronae*: supervisor of the Crown's pleas
- *modus operandi*: method, formula
- *mens rea*: criminal intent; prior intention to commit a criminal act, without necessarily knowing that the act is a crime

#### *Abbreviations*

- Advanced Nursing Practice (ANP)
- Advanced Practice Nursing (APN)
- American Nurses Association (ANA)
- Canadian Nurses Association (CNA)
- Forensic Nurse Examiner (FNE)
- International Association of Forensic Nurses (IAFN)
- Sexual Assault Nurse Examiner (SANE)
- Sexual Assault Response Team (SART)
- Saskatchewan Registered Nurses Association (SRNA)

### Organization of the Dissertation

In this study I explored forensic nursing education through the perceptions of forensic nurse educators who developed and taught some of the earliest established programs. In Chapter One, I presented the *Introduction to Forensic Nursing Education*, the context and purpose of the study. I outlined the research questions along with an explanation of the placement of the study and background of the researcher. I described limitations of the research, in addition to defining key terms used in the study. In Chapter Two, *Review of Relevant Literature and Research*, I explored the knowledge of the forensic disciplines by reviewing the origins of forensic medicine and forensic psychiatry

that are the roots of many of the forensic nursing subspecialties. I identified the issues that influenced the practice and role development of forensic nursing in the literature. I traced the chronological development of forensic nursing as a specialty and the history of forensic educational development to date along a chronological pattern of specialty development. In Chapter Three, *Research Design and Methodology*, I provided an overview of the research design, methodology and methods of data analysis used for this study. I addressed the choice for using an explorative constructivist paradigm as well the methods of data collection, instrumentation, and analysis. In Chapter Four, *Data Analysis (Phase I) Descriptive Statistics*, I compiled frequency distributions of the educators' demographic data and course content information and correlated them where applicable to data extracts from the qualitative interview in phase II of the data analysis. In *Data Analysis (Phase II) Qualitative Interview*, I examined data from the interviews using a thematic analysis. In Chapter Five, *Findings*, I identified and summarized the main typologies and knowledge themes of the study and compared them to the literature to show outside support for the data findings. I provided segments of the actual data in the form of data extracts as useful explanatory material and summarized each theme in a constructivist interpretation. Finally, in Chapter Six, *Discussion, Implications, and Conclusion*, I discussed the key findings of the study with implications for theory, practice, and education. I summarized the knowledge of forensic nursing in comparison to existing knowledge and noted recommendations for future research.

## CHAPTER TWO

### REVIEW OF THE RELEVANT LITERATURE AND RESEARCH

By the end of the 20th century, forensic nursing courses and programs began to steadily increase in numbers and in demand at the post diploma, graduate, and doctoral level. In Chapter Two, a review of the literature is provided to explore the history of forensic nursing as a specialty and its evolution to specialty status and educational development. The origins of nursing, forensic medicine, and forensic psychiatry provided an understanding of the roots of forensic nursing and its many subspecialties with their relationships to nursing science, forensic science, and criminal justice. This research is grounded within the larger extant literature on the issues of this specialty debated in the prose. The impact of societal movements, media power, and technological advances on the development of forensic education, is examined along with the role and responsibility of leaders in the field.

#### *Purpose of the Literature Review*

The historical development of forensic nursing and issues that influenced the development of forensic nursing education provided the foundation for the literature review. “A good literature review has a clearly defined logic in the service of only one goal: making the case for the proposed study” (Sandelowski & Barroso, 2003, p. 784). By identifying the studies done on the need for forensic nursing education, this study is positioned within the timeline of educational research needed for this specialty as courses are developed and disseminated to students the world over.



### *Method of Literature Review*

Within the electronic searches, I utilised a wide and varied spread of search terms both in conjunction and singularly. These terms included: forensic nursing, forensic nursing education, forensic nursing research, forensic nursing specialization, forensic nursing roles and issues, forensic psychiatry, forensic medicine, and forensic science. The databases I used were: CINAHL Plus, Medline, and PsychLit covering the span from 1990-2007. I conducted a number of additional searches using author names identified during the initial electronic search. Literature was also drawn from my personal collection of seminal forensic nursing articles published prior to the availability of electronic databases that dated back from 1969-1989. The literature search resulted in the production of a bibliography comprising of 621 references from 87 different journals and books spanning 38 years of publications and included 881 authors.

For this study, I followed a *gap logic* in that the review was orientated to show what is still missing in the domain of research integration and reasons for this gap. The literature review neither provided key concepts nor suggested a hypothesis, as it typically does in hypothetical-deductive research. Instead my literature review showed gaps and bias in the existing knowledge, thus providing rationale for a qualitative constructivist study. As Braun and Clarke (2006) noted, a constructionist method allows the researcher to examine the ways in which events, realities, meanings, and experiences are the effects of a range of discourses operating within society. I used this research approach to answer questions about why social processes evolved the way they did and to describe and explain influencing factors.

## Nursing Science Knowledge

I overviewed in this section the origins of nursing science, nursing education, and nursing specialization as a background to the historical development of the forensic specialties that evolved from, or in reaction to, the needs and events in society. I traced policies, laws and acts, and social movements through a timeline of events that resulted in and influenced forensic nursing as a specialty and its educational development.

### *Nursing Science--Origins and Historical Development*

Nursing as defined by Leininger (1984) is the art and science of caring. Seen as an art, nursing encompasses intuitive, expressive, subjective, creative, humanistic, and holistic dimensions that find expressions through our therapeutic use of self. Meanwhile “the science of nursing is that body of knowledge unique to nursing” (Kent-Wilkinson 1993, p. 25).

Nursing as a profession represents the largest group of knowledge workers in today’s knowledge society. Teaching, the first or oldest knowledge profession was invented in 1794, the year the Ecole Normale was founded in Paris. Sixty years later, Florence Nightingale during the Crimean War of 1853 to 1856 founded what would become the second oldest knowledge profession, but the largest health care profession (Drucker, 2002). The human being, as the knowing subject, and object of knowledge of the human sciences was, according to Foucault, permitted to emerge by the decline of the classical regime (at the end of the eighteenth century) as a categorization in disciplinary blocs by professionals in the human sciences (Foucault, as cited in Marshall & Peters, 1999).

### *Nursing as a Professional Discipline*

The nature of nursing and the need for knowledge distinct from medicine was first

articulated by Nightingale in 1859 (Nightingale, 1957). Since that time there has been substantial effort committed to the development of a distinct theory base for nursing. In the early 20<sup>th</sup> century, nursing was defined as an intuitive function performed by well intentioned, well meaning people with an innate ability to care for the sick (Josberger & Ries, 1985). Nursing as a profession was in its embryonic stage. In the 1940s, nursing defined its scope as *total patient care*. Advances in technology, pharmacology research, clinical medicine, and treatment dictated the need for more highly trained and skilled nurses. These advances changed the profession dramatically as “the complexity of patient’s needs was recognized, intuitive judgments by nurses were no longer adequate” (Yura, as cited in Josberger & Ries, 1985, p. 68).

The concept of *total patient care*, of the 1960-1970s evolved into one of *holistic care* when nursing was defined as assisting people to achieve their maximum health potential (Josberger & Ries, 1985). Underlying this concept are concepts of health maintenance, health promotion, disease prevention, caring for peoples with illnesses and rehabilitative care.

The focus on nursing as a professional discipline emerged most prominently in the 1970s and 1980s. A number of concepts have been identified as central to the study of nursing. An example is the frequently cited tetralogy: person, environment, nursing, and health (Fawcett, 1984; Flaskeud & Halloran, 1980). The concept of *caring* has also occupied a prominent position in nursing literature and has been touted as the essence of nursing (Benner & Wrubel, 1989; Leininger, 1984; Watson, 1985). “In the 1980s, the nurse provided services in all settings, not necessarily identified with traditional health illness services, and focused not only on the clients but also on the client’s interactive groups and environment”

(Josberger & Ries, 1985, p. 68). In the last twenty-five years, advanced practice and education and expanded roles has positioned nursing as a significant member on the interprofessional team.

### *Nursing Education*

Formalized nursing education began after worldwide recognition of the work of Florence Nightingale. The secularization of nursing was explained by the appearance in London in 1860 of Florence Nightingale's school at St. Thomas's Hospital, which offered the probationer comprehensive medical and nurse training and provided the pedagogical leverage necessary for worldwide progress (Williamson, 2000). Historically, nursing education that began in the United States in 1872 and in Canada in 1874, both were based on an apprentice system of hospital training (Davis, 2004). Students learned on the job, mainly in hospitals through observation and sharing of knowledge by experienced nurses. Drucker (2002) cited the hospital, as the most complex human organization ever devised, and nurses as the largest of the many professional health disciplines with their own rules and regulations, and its own education. In the 1970s, nursing moved into the universities, and through the work of professional associations, the baccalaureate level as entry to practice became standard in the developed countries.

The basic nursing curriculum focuses on a strong physical and psychological science base. This foundational base includes human anatomy and physiology, biology, behavioral sciences, nursing arts and theory, and general courses in the humanities. Upon completion of a degree program, the candidate is qualified to write the Registered Nurse Examinations to obtain license to practice, as outlined by the professional registration or licensing bodies in

each state or province. Graduate and doctoral programs are also available at most universities.

The practice of nursing continues to evolve to meet the changing needs of clients. The 1980s witnessed the development of a variety of formal and informal nursing specialty educational programs. Recognition of a specialist area of practice is greatly advanced with educational tracks that promote the specialization of the discipline.

### *Nursing Specialization*

Traditionally, nurses have been trained as generalists and nurses with extensive clinical experience in a particular area of practice are considered specialists. The view through the knowledge base lens shows that it is impossible to know about all aspects of nursing. By the 1980s specialty educational courses were developed in specific practice areas like oncology, perinatal, and gerontology and these specialties sought certification and specialty status.

Changes made by health care administrators in the delivery of health care provided opportunities for nurses to create new roles and expand current ones. New roles in nursing were developed in ways that promoted excellence in client-centered care and that were in the public's best interests (CNA, 2002a; 2002b). "As nurses move along the continuum of experience and education, they acquire additional competencies that are incorporated into their practice. These competencies and skills enable nurses to contribute to the health care system in new ways" (CNA, 2002a, 2002b). With new skills and additional education, focused specialty areas developed.

### *Requirements Constituting a Specialty*

Specialized areas of nursing are often developed in response to needs in society (Cummings, 1995). A specialty or specialty occupation requires a body of theoretical and practical application of highly specialized knowledge; a specialty has a legally approved/recognized certification program, which tests the attainment of well documented standards (American Board of Nursing Specialties, 2005). The Canadian Nurses Association (1982) defined specialty as a “specified defined area of clinical and functional nursing with a narrowed, in-depth focus, necessary for the safe delivery of the full range of services required in that area of nursing” (p. 25). The International Council of Nurses (1993) defined specialization in nursing as, “a level beyond basic nursing education” (p. 1313).

### *Patterns of Stages of Specialty Development*

Specialties in nursing usually follow a similar pattern of development, with a number of issues needing to be addressed for any given nursing specialty to evolve. Using Hanson and Hamric’s (2003) three stages of specialty evolvement, I outlined the development of nursing specialties:

*Stage 1, Specialty development in practice setting.* In the first stage of specialty development, changes in patient needs, new technology, and changing opportunities within the workforce begin to occur within practice settings, driving the development of a specialty focus. In the past, this change often meant that nurses took over activities that were not valued by physicians or took on additional tasks in settings where there was an insufficient physician supply. In the initial coalescing period, the specialty may not be seen as exclusively a nursing role (Hanson & Hamric, 2003).

*Stage 2, Organized specialty training.* In the second stage, the specialty progresses to the point that organized training is developed for nurses. In much the same way that nursing education began with on-the-job training in hospitals, early specialty education was characterized by an apprenticeship model (Hanson & Hamric, 2003).

*Stage 3, Standardization and emergence of graduate education.* The third stage of a specialty develops as the specialty's knowledge base grows and the scope of practice of the nurses with specialty training expands. There is growing recognition of the additional knowledge and skills needed for increasingly complex practice in the specialty. The third phase is characterized by pressures for standardization of education and skills, involved in the specialty. In the past 30 years, this phase has been coupled with pressure to move certificate-level training programs into formal graduate-level educational settings, both as a means to increase standardization, and to raise the standards of the specialty to an advanced practice level (Hanson & Hamric, 2003), or to a nurse practitioner level at the graduate level.

Trends in the delivery of health care have provided opportunities for nurses to create new roles, and expand current roles through specialization. The emergence of knowledge as an important resource increasingly means specialization. Drucker (2002), a postmodern economist, contended that "knowledge is effective only if specialized" (p. 259). Specialty nursing emerged as a consequence of the knowledge explosion, technological advances, and policy decisions that resulted in the creation of specialized institutions and units. In order to work in specialty areas, nurses require in-depth knowledge about a narrow field of nursing (Joachim, Saxe-Braithwaite, Mass, Calnan, Mann, & Ratsoy, 2003).

### *Forensic Nursing Science*

As a nursing specialty, forensic nursing incorporates areas of nursing where nurses care for victims, offenders (living or deceased), and their families, where their practice area interfaces with the law in some way. Forensic nursing encompasses a wide and diverse group of nurses and can be described as the nursing specialty that integrates elements of many sciences: nursing science, forensic science, and criminal justice in identifying, collecting, processing, and managing data and information to support nursing practice, administration, education, research, and the expansion of the body of nursing knowledge. Forensic nurses practice in the complex organization of the health care system, but they have learned to interface with, and navigate through many other systems – the criminal justice system, the child welfare system, the medical examiner/coroner system, and the mental health care system, within all of which they provide nursing services. Many other health care disciplines are also focusing on the forensic aspects of their practice and identifying themselves as a forensic specialty (e.g., forensic psychiatry, forensic psychology, forensic social work, and forensic occupational therapists).

Different from most nursing specialties, forensic nursing is made up of different areas of nursing practice. Subspecialties of forensic nursing are: clinical forensic nursing (victims of interpersonal violence), forensic correctional nurses (offenders), forensic nurse examiners (sexual assault survivors), forensic nurse death investigators (deceased), forensic psychiatric/mental health nurses (mentally ill offenders), forensic geriatric or pediatric nurses (victims of abuse and neglect).



In the stages of specialty development each subspecialty of forensic nursing had its own history and educational development and had been influenced by societal trends, health care and/or prison reforms, and public awareness. Although, the sexual assault nurse examiner role developed for the most part simultaneously with education, this was not the case for most all of the other forensic nursing subspecialties, as other subspecialty roles of forensic nursing developed ahead of any formal specialty education.

In addition to forensic nursing's roots being in its discipline base of nursing science, forensic nursing also has strong links to two distinct areas of forensic science: forensic medicine and forensic psychiatry. The specialty of forensic nursing evolved just as other specialties of forensic medicine and forensic psychiatry did when there was a societal need for a specific medicolegal role.

### Forensic Science Knowledge

Forensic science, according to American Academy of Forensic Science's definition in 1989, was "the application of scientific principles and technological practices to the purposes of justice in the study and resolution of criminal, civil and regulatory issues" (American Academy of Forensic Sciences, 2007). Some of the forensic science (physiological or biological) disciplines are: forensic anthropology, forensic dentistry, forensic entomology, forensic medicine, and forensic odontology.

### *Forensic Medicine--Origins and Historical Development*

Forensic medicine is the branch of medicine that has a specifically legal purpose, for example, establishing the cause of a death (Encarta dictionary, 2007). I explored the physiological science of forensic medicine here to provide an understanding of one

subspecialty of forensic nursing (forensic nurse investigators) having its roots in this area.

### *Greece*

The application of forensic science has been recorded as early as 400 B.C. in Greece, with the medical examination of the Greek philosopher, teacher, and writer Socrates, to validate that suicide was the cause of death. Suicide was viewed “as an act of rebellion against the gods” (Bader, 2005, p. 22). This documentation of suicide was the earliest account where a medicolegal opinion was required to determine the manner of death in order to allow for the established religious funeral rights to be conducted. If the manner of death was ruled a suicide, funeral rights would be denied, as suicide would be classified as a crime against religion.

### *England*

Similarly, forensic medicine evolved in England in the 1100s from the medicolegal need to determine cause of death, so that the decision to impose a suicide penalty could be rendered (Henson, 1987) and to prevent financial abuses against the crown (Schramm, 1991). As a result, the role of coroner began for the purpose of preventing financial abuses against the crown by English Sheriffs. In 1194, the office of coroner in England was formally described along with the mechanism whereby appointment was to be made (Henson, 1987; Spitz & Fisher, as cited in Schramm, 1991). The title of "Coroner" was given to each knight who took custody of a deceased felon's property, thereby enriching the royal treasury. The title derives from the Latin "*Custom placitorum coronae*" or "Supervisor of the Crown's pleas" (Chien, 1996).

### *China*

The oldest extant book on forensic or legal medicine in any civilization has long been recognized as the 13<sup>th</sup> century book, *Xi Yuan Ji Lu* (洗冤集錄, translated as "Collected Cases of Injustice Rectified"), written in 1247 in China by Song Ci 宋慈, 1186-1249. The title can be paraphrased as "Instruction to Coroners" and details the procedure to be followed in the investigation of suspicious deaths" (as cited in Chien, 1996). The book offered useful advice, such as distinguishing drowning (water in the lungs) and strangulation (pressure marks on the throat and damaged cartilage in the neck) from death by natural causes (Almirall & Furton, 1995).

### *Europe*

In 16<sup>th</sup> century Europe, medical practitioners in army and university settings began to gather information on the cause and manner of death. Ambroise Paré, a French army surgeon, systematically studied the effects of violent death on internal organs. Two Italian surgeons, Fortunato Fidelis and Paolo Zacchia, laid the foundation of modern pathology by studying changes which occurred in the structure of the body as the result of disease (Wikipedia, 2007a). In the late 1700s, writings on these topics that began to appear included: "A Treatise on Forensic Medicine and Public Health" by the French physician Fodéré, and "The Complete System of Police Medicine" by the German medical expert Johann Peter Franck (Wikipedia, 2007a).

### *United States*

The discipline of forensic medicine began in the 1600s and concentrated on pathology

and cause of death. In the 17<sup>th</sup> century, the system of laymen coroners traveled from the Old World to the British colonies. In the New England settlements, Paul Revere and other coroners were popularly elected and had no medical training. Later, the office of the coroner was entwined with the political system and became politically powerful (Chien, 1996). “The coroner system, copied from the English coroner system, began in the United States on January 29, 1637” (Fisher, as cited in Henson, 1987, p. 76) and for 200 years the US coroner system remained unchanged as a generally popular elected county official who need not be medically trained (Henson, 1987, p. 76).

The coroner system remained common throughout the United States until 1915, when New York State abolished the coroner system and established a system of medical examiners (Spitz & Fisher, as cited in Schramm, 1991). The American Board of Pathology recognized forensic pathology as a sub-specialty in the early 1950s (Chien, 1996). The old system of electing a lay person to be coroner was gradually replaced with medical examiners’ offices (Henson, 1987; Schramm, 1991) to where the medical examiner’s system is now prominent in the United States. Under the medical examiner system, the medical examiner is the head of the department and is a board-certified forensic pathologist who directs and appoints the personnel of the department. “Coroners continue to preside predominately in rural areas in the United States and serve exclusively in Alaska, Idaho, Nebraska, and North and South Dakota” (Goldsmith, as cited in Schramm, 1991, p. 673).

“In the United States there are approximately 350-450 full time forensic pathologists. An estimated 800-1000 are needed in the US” (personal communication, Dr. Corrie May, November, 2, 1996). “Forensic pathology in the United States is the second smallest

specialty in the entire field of medicine” (V. Lynch, personal communication, July 14, 1996).

In 1948, the American Academy of Forensic Sciences (AAFS, 2007) was formed. AAFS is a non profit professional society dedicated to the application of science and the law.

### *Forensic Medicine Education*

Forensic medicine is now rarely taught at the undergraduate level. There are clear educational pathways to forensic pathology and forensic medicine offered in selected medical schools, globally.

### *Forensic Nurse Investigators (Nurse Death Investigators/Nurse Coroners)--*

#### *Origins and Historical Development*

A five year study was conducted in the mid 1970s to determine the appropriate discipline for the role of death investigator. The findings showed that nurses best met the criteria due to their biomedical education, their knowledge of medical terminology and pharmacology, and their psychosocial skills. These skills prepared nurses effectively to serve as the medical investigators: being present at the death scene, handling confidential material, and relaying sensitive information to family members (Lynch, 1993a). Since that time this model for the nurse as the medical investigator has spread internationally.

### *Canada*

The forensic sub-speciality of nurses as medical death investigators is recognised internationally as having its historical roots in Alberta, Canada. The Medical Examiners’ Office in the Province of Alberta, Canada, came into effect in 1977, after passage in the Legislature of the Fatality Inquiries Act. This Act facilitated the adoption of the medical examiners system for investigation of all deaths which occurred unnaturally, unexpectedly, or could not

be explained” (Stewart, 1984, p. 13). “In 1977, nurses as death investigators or medical examiner’s nurse investigators commenced in the ME’s offices in Calgary, Alberta in a program established by Dr. John Butt MD, Chief Medical Examiner of Alberta” (Lynch, 1993b, p. 7).

In Canada, four provinces operate under the medical examiner system--Alberta, Manitoba, Nova Scotia, and Newfoundland, and the other six, have a coroner system or a combination of both. Registered nurses have held the position of coroner in some territories and provinces (D. Chein, personal communication, June 2, 1995).

#### *United States*

Nurses as death investigators began in this role in the mid to late 1970s, in Miami, Florida. The program was established by Dr. Joseph Davis of the Dade County Medical Examiners Department (Lynch, & Burgess, 1998). Courses to train nurses as death investigators began in 1996 in Dade County, Miami, Florida (Lynch, & Burgess). Although much pioneering is yet to be done to establish the nurse in the death investigator role – nursing positions are established in the following areas: Miami, Florida; Louisville, Kentucky; St. Louis, Missouri; and an internship training program was established in Reno, Nevada where courses were offered by nurses in these locations (Lynch, & Burgess).

#### *Forensic Nurse Investigator--Education*

As positions for nurse (death) investigators are few in numbers, only a small number of programs have been established to consistently train nurses in this specialty area. Students need to be advised that available death investigation positions are rare even in the big cities in North America. Most of the investigators are there for the length of their career, so

positions often only come up when an investigator retires. For the most part, nurses have been trained-on-the-job for positions in medical examiners' offices. Some nurses are trained as a deputy coroner. Once this title is achieved, advancement to Chief Coroner can be obtained with time, experience, continuing education, and an extensive training program offered in conjunction with the state attorney general's office.

### *Clinical Forensic Medicine--Origins and Historical Development*

Clinical forensic medicine is the "the application of clinical medicine to victims of trauma, involving the scientific investigation of trauma and proper processing of forensic evidence" (McNamara, as cited in Lynch, 1991, p. 70).

### *Police Surgeons--History*

Police surgeons are general practitioners or physicians. "Since police surgeons are neither policemen, nor surgeons the name is somewhat of a misnomer and the term 'clinical forensic medicine' is therefore a more apt description of their work" (Doney, 1984, p. 185). Police surgeons of the United Kingdom are practitioners (generalists who are primarily family doctors) of clinical forensic medicine. In countries where they exist, such medical officers are contracted by and paid by police authorities to provide twenty-four hour services when problems arise requiring medical expertise to resolve them (Doney). For many years, police surgeons, like doctors in other disciplines, worked in isolation and there was little educational or organizational cohesion. In 1951, The Association of Police Surgeons of Great Britain was formed and proved to be a dynamic and meaningful organization dedicated to the organization of well informed, well trained, and well qualified, practitioners in clinical forensic medicine (Doney).

### *Clinical Forensic Medicine--Education*

One unique feature of clinical forensic medicine in the United Kingdom is a postgraduate academic examination. Physicians can take the examination and obtain the Diploma of Medical Jurisprudence (D.M.J.) after suitable instruction and a qualifying apprenticeship (Doney, 1984). Police surgeons so qualified are accepted by their legal profession as experts in their fields. They are available to be called by the prosecution or by the defence. In the academic field, some police surgeons teach in universities and other are examiners in the diploma examination. Many police surgeons travel abroad and have contributed significant papers to international congresses (Doney).

In September, 1984, in Oxford England, the International Association of Forensic Scientists recognized the specialty of clinical forensic medicine, by introducing for the first time a clinical forensic medicine section into its program (Doney, 1984). In 1990, the first medical school offering a formal residency program in forensic clinical medicine established in Louisville, Kentucky (Busutti, & Smock, as cited in Lynch, 1993b). "Clinical forensic practice is based on the role of the police surgeon in the United Kingdom" (Lynch, 1993b, p. 8) and Lynch noted that the role of the police surgeon in the United Kingdom was the forerunner of clinical forensic nursing.

### *Clinical Forensic Nurses (Interpersonal Violence)--History*

Clinical forensic nursing is "the application of clinical nursing practice to trauma survivors or to those whose death is pronounced in the clinical environs, involving the identification of the unrecognized, unidentified injuries, and the proper processing of forensic evidence" (Lynch, 1995a, p. 491). Forensic nurses have been instrumental in the



development of tools for the assessment of domestic violence. Roles for clinical nurse specialists in the area of interpersonal violence have become a recent new role in large trauma centers. Here nurses lead the multidisciplinary team in the assessment of child abuse, elder abuse, spousal abuse, and in the awareness of the reporting laws and policies for their jurisdiction.

*Clinical Forensic Nurses--Education and Research*

Davila (2005) from the University of Michigan, School of Nursing noted that despite the prevalence of domestic violence and its recognition as a priority health issue, the majority of accredited nursing schools in the United States has yet to adequately integrate violence assessment and intervention content and planned clinical experiences into their curriculum. Nurses and the public are now requesting education to develop nursing assessment skills to better care for their domestic violence (D.V.) patients.

*Forensic Nurse Examiners (Sexual Assault)--Origins and Historical Development*

This forensic nursing role may have had its early roots in the 18<sup>th</sup> century in Europe, when midwives testified in court on matters such as virginity, pregnancy, and rape (Lynch, & Burgess, 1998). However, it was the end of the 20<sup>th</sup> century before nurses pioneered this role. In the mid-1970s, emergency nurses in large urban hospitals in the United States identified a need to serve sexual assault victims. Emergency nurses were concerned that most sexual assault victims had to wait many hours in busy departments until the emergency physician could conduct the needed medicolegal examination (Ledray & Arndt, 1994). Nurses felt they could perform the sexual assault exam, document the findings, provide increased emotional support with consistent follow-up care, and generally provide services that lead to improved

legal outcomes. The development of sexual assault nurse examiner (SANE) programs began when healthcare providers realized that the then-existing standard of care was inadequate for sexual assault victims in hospital emergency departments. Historically, sexual assault victims were treated by physicians and nurses who had little or no training in forensic evidence collection (Fagan, Houmes, & Quintana, 2003). Today, this role is performed by specially trained nurses called SANEs who provide comprehensive care to victims of sexual assaults.

#### *SANE/SART--Education*

Nurses began to develop [their own training courses](#), thereby creating a role for themselves as sexual assault nurse examiners (SANEs) or on sexual assault response teams (SARTs). Nurses provided services in their own distinct clinics, or in specified areas separate from hospital emergency departments.

*United States.* The first sexual assault nurse clinician/examiner programs were developed by nurses who were concerned about the lack of adequate care after the crisis of sexual assault (Ledray & Arndt, 1994). For this subspecialty, education was developed at the same time as the role developed. In 1976, the first SANE program was established in Memphis, Tennessee. In September, 1977 the Sexual Assault Resource Service began in Minneapolis, Minnesota (Ledray, 1992). In 1978, the sexual assault nurse clinician program began in Amarillo, Texas (Ledray & Arndt, 1994).

Sexual assault nursing has become the largest forensic nursing subspecialty group. Not only have the sexual assault nurse examiners pioneered their own nursing roles, but they were pivotal in founding an international organization of forensic nurses that encompasses all nurses who practice at the interface of law and nursing. There were 26 sexual assault nursing

programs represented when the International Association of Forensic Nurses (IAFN) was formed in 1992. As a result of the formation of the IAFN, collaboration occurred between the various sexual assault programs that were already in existence (Ledray, 1997). Sexual assault nursing leaders who were also IAFN members published their “Sexual Assault Nurse Examiner Standards of Practice” (IAFN, 1996). The IAFN established educational guidelines for SANE training in the criminal justice system that covered such topics as the role of courtroom personnel, SANE testimony procedures, the criminal justice process, and strategies used by attorneys (W. K. Taylor, 2002). Researchers from Summa Health System and Northeastern Ohio Universities, College of Medicine, both in Akron, offered the first widespread educational survey of SANE programs throughout the United States (Voelker, 2000). By 1998, 117 programs had been established in 38 states, and in 2006 there were 404 identified American SANE programs, and 10 Canadian programs (SANE-SART, 2006).

*United Kingdom.* The SANE roles and SANE programs in other countries has been slower to develop than in the United States. A much smaller population base may be partly the reason for programs appearing later in the United Kingdom. In 1986, the St. Mary’s Sexual Assault Referral Center opened in Manchester, England. The center was a joint venture between Central Manchester Health Care NHS Trust and Greater Manchester Police. The referral center offered the most extensive service in the United Kingdom for the survivors of rape and sexual assault. The center’s staff liaised with the police in the careful and meticulous gathering of evidence. Most of the crisis workers had a nursing background and brought their nursing skills to the role (Mansley, 1998).

*Canada.* Sexual assault nurse examiner training programs began in Winnipeg, Manitoba in the late 1980s, while British Columbia and Ontario began in the early 1990s, Alberta started in the later part of the 1990s, and in Nova Scotia, a SANE training program was established just in 2000. More specifically, the first sexual assault nursing program in Canada started at the Health Sciences Centre and Woman's Hospital in Winnipeg, Manitoba in 1989. It began as a physician-assisted sexual assault program. In April, 1993 the sexual assault nurses in Winnipeg received transfer of function to perform a speculum examination for the purpose of forensic examination (B. Ariss, personal communication, February 13, 1998). A nurse examiner program was established in the fall of 1993 in Vancouver, British Columbia (L. Ritch, personal communication, April 20, 1998), and in January of 1994, the Surrey Memorial SANE program began in Surrey, British Columbia (S. Early, personal communication, April 22, 1998).

Nurse examiner programs have been in place throughout Ontario as a provincial coordinated effort since October, 1995 (personal communication, S. MacDonald, April 22, 1998), although the Ministry of Health had funded the first Sexual Assault Care Centers as early as 1984. Grant MacEwan College, in Edmonton, Alberta offered Alberta's first sexual assault course in July, 1998. The first sexual assault response team (SART) in Alberta was launched in 2000 (Kent, 2000). SANE training and caring for victims of sexual assault began in Nova Scotia in January, 2001 (Government of Nova Scotia, 2001).

To date, ten sexual assault training programs are offered (SANE/SART, 2006) of which only five of Canada's 10 provinces have sexual assault training programs established. Lower population rates is a possible reason SANE programs have been slower to develop in

Canada. Development of the sexual assault examiner role in the United States has helped countries like Canada establish the role as well.

To work as a SANE, training consists of a five-day course that yields a certificate. Training can take place in or out of state or province as long as the nurse then links to the community sexual assault response team where they will be practicing. There is a need for nurses to be aware of local regulations and facility protocols that affect their practice. Theoretical sexual assault training courses are also beginning to be available for credit at a few universities and colleges as a three credit course within a forensic nursing certificate program.

#### *SANE--Research*

Studies by Ledray and Simmelink (1997) in the midwest United States reported a higher rate of offender conviction due in part to the proper collection of evidence in cases handled by sexual assault nursing services. Du Mont and Parnis (2003) in Toronto, Ontario, Canada, conducted a population-based study on SANE training programs. They compared nurses who had participated in a SANE program to nurses who had not participated in the program on their opinions and practices in relation to the collection of forensic evidence. The findings showed that SANEs were more likely to indicate that certain samples, items, or questions should not be used as a regular part of the forensic examination. They were less likely to perceive the presence of physical injuries and semen and/or sperm as being “extremely important” to a positive legal outcome. These findings had implications for care offered to victims of sexual assault. In addition, more SANEs reported experiencing

dilemmas with respect to their dual roles as caregivers and evidence collectors (Du Mont, & Parnis).

Studies consistently indicated that forensic nurses with subspecialty certification in sexual assault examination generally provide better and timelier care (Plichta, Clements, & Houseman, 2004) and are more competent at collecting evidence that met legal standards (Sievers, Murphy & Miller, 2003, as cited in Plichta et al., 2004).

#### Forensic Behavioural or Social Sciences Knowledge

In contrast to the physiological sciences of forensic science, the forensic behavioural (social sciences or clinical sciences) deal with the legal aspects of human behavior and are represented by disciplines like forensic psychiatry, forensic psychology, forensic social work, and forensic nursing, who interface with the criminal justice system. Forensic nursing, therefore, can be described as a specialist branch of nursing with connections both to the forensic sciences (physiological and biological approaches) and the forensic behavioural sciences (clinical and social science approaches) in that their subspecialties are concerned with the care of victims, offenders, living, and deceased, at the legal interface.

#### *Forensic Psychiatry--Origins & Historical Development*

The term *forensic* is derived from the Latin term *forensis* which means *of the forum*. In 1659, the term was anglicized to *forensic*. “Just as the emergence of medicine dominated the body, so the advent of psychiatry governed the mind” (Mason & Mercer, 1996, p. 153). Forensic psychiatry began in many countries when physicians were called upon to provide the courts with an understanding of the mind. From a historical perspective the Romans established the forum, and hence the term forensic psychiatry has meant "the psychiatry of

the court". "What is law but the regulation of human behaviour?" (personal communication, T. Dalby, May 6, 1997). Forensic psychiatry began as a discipline in many European countries when it became apparent that many of the crimes people with mental disorders were committing resulted from not being mentally capable of doing otherwise, at the time the crimes were committed.

Psychiatric glossaries define forensic psychiatry as a branch of psychiatry dealing with legal issues related to mental illness (Alberta Forensic Psychiatry Services, 1997). Forensic psychiatry is a subspecialty of psychiatry; it encompasses the interface between law and psychiatry, in which scientific and clinical expertise is applied to legal issues and legal context embracing civil, criminal, correctional, or legislative matters; forensic psychiatry should be practiced in accordance with guidelines and ethical principles enunciated by the profession of psychiatry" (American Academy of Psychiatry and the Law, 1979; American Board of Forensic Psychiatry and Neurology, 1979).

### *United Kingdom*

*1200s.* In the 1200s, "the insane, criminals & vagrants were all housed together and anyone else that did not fit into society" (Yonge & Osborne, 1991, p. 8). In 1275, the *First Statute of Westminster* demanded defectives be cared for and treated by harsh punishment in prison (Mason & Chandley, 1990). A 13<sup>th</sup> century legal administrator, Henry De Bracton, wrote in the document "On the Laws and Customs of England", the following statement: "a crime is not committed unless the will to harm be present" (Miller, 1998, p. 3).

The development of deterministic causal thought, which was linked to the growth of technology and trade, gave medicine a new impetus and methodological foundation. In

judicial matters it encouraged the use of medical experts. In the field of demonology, in particular, physicians motivated by scientific and humanitarian interest refined their interpretation of diabolical phenomena opposing theological explanations (Miller, 1998). In 1492, lawful incarceration of the *dangerous lunatic*, either in his own home or the local bridewell was facilitated by common law (Mason & Chandley, 1990, p. 668).

1970s. With regard to prison reforms and prison health care, in the late 1700s, “prison reforms introduced some of the basics of public health: inspection, cleanliness and white-washing the walls” (Alexander-Rodriguez, 1983, p. 115), and a basic ethic of humanitarianism. Although some individual prisons had earlier employed surgeons, it was the *Health of Prisoners Act* in 1774 that provided local justices with the authority required to ensure minimal health standards within prisons could be maintained. “The initial emphasis was on the preservation of the physical health of prisoners, particularly, the maintenance of a basic standard of hygiene and cleanliness” (Senior, 1998, p. 231).

The Trial of Hadfield in 1799 set a legal precedent for the “insanity defence” (Cohen, as cited in Mason & Chandley, 1990). Public reaction to the results of high profile cases shaped the law. After Hadfield was acquitted on grounds of insanity of attempting to assassinate King George III, provision was made to detain such persons at the pleasure of His Majesty (Mason & Mercer, 1998).

1800s. “With the Insanity Bill of 1800, insanity was now seen as a medical problem rather than a community, social or religious complication” (Mason & Chandley, 1990, p. 668). Forensic psychiatry began in England around the mid-1800s, when physicians were called upon to provide for the courts an understanding of the mind. It has been noted that the



penetration of psychiatry into the criminal justice arena occurred in a period extending over 30 years between 1799 and 1830 (Foucault, 1978). During this time, courts began accepting psychiatric interpretations as a rationale for mitigation and leniency in certain cases. From this initial incursion forensic psychiatry claimed the criminal as a foundation for its expanding professional territory” (Mercer, Mason, & Richman, 2001, p. 107).

In 1895, the Report of the Gladstone Committee recommended that all prison medical officers should have some experience in the subject of lunacy (Senior, 1998), thus “the acknowledgment of the likelihood that the mentally disordered would remain a significant presence in the prisons” (p. 232). Policies for systems and services to house mentally ill offenders provided us with a glimpse of society, at that time. Precedent setting laws like the *insanity defense* brought about the placement of mentally ill offenders into the care of the special asylums.

*1900s.* In the 1900s, the prison medical officer (PMO) covered more than the direct concerns of an inmate’s day-to-day welfare. Medical officers were expected to monitor standards of food and hygiene, and certify prisoners fit for labor, punishment, or transfer. At the same time they provided expert opinion for the courts pronouncing upon whether prisoners should be granted liberty (Senior, 1998). As the twentieth century unfolded, prison officers expanded the services they offered; notably the provision to courts of reports upon the mental conditions of offenders. “This established for doctors, and psychiatrists in particular, the role of expert witness within the criminal justice system” (Senior, p. 233).

*1940s.* The event of the National Health Service (NHS) being established in 1948 did not change the prison medical structure significantly, because the Prison Medical Service

(PMS) continued to be run separately as part of the Home Office (Polczyk-Przybyla & Gournay, 1999). But the psychiatric services expanded and the Commissions of Prisons acknowledged that: while medical practice offers considerable opportunity for experience in physical medicine, it is recognized that the greater part of the work lies in the psychiatric field (Commissioner of Prisons, Gunn, as cited in Polczyk-Przybyla & Gournay, 1999).

*Role of nursing in the U.K.* Although the birth of forensic psychiatry was recognized when psychiatrists were called upon to testify in courts about the mental state of the accused, it would be another hundred and fifty years before professional nurses would be established as the primary provider of health care for the offender, and for the mentally-ill offender. The first recorded nurse was appointed to cater for the needs of the physically sick residents in Bethlem Hospital, United Kingdom in 1693; this post later was combined with that of matron, a position usually occupied by the steward or porter's wife (McMillan, 1997, p. 31).

In 1845, the name "attendant" was introduced at Bethlem Hospital (McMillan, 1997, p. 31). The 1893 Annual Report referred to attendants and nurses as "servants" even though some had passed Certificate of Proficiency in Mental Nursing examinations (p. 31). The origins of forensic psychiatric nursing can be located in the functions of the nineteenth century asylum attendant. "Prison health nursing is predicted, like all nursing upon a basic ethic of humanitarianism" (Alexander-Rodriguez, 1983, p. 115). Historical documents of Florence Nightingale (1859/1957) linked nursing to forensic roles of caring for prisoners of war, and the development of public health policies.

*1900s.* In the early 1900s, "all female attendants were renamed sisters, staff nurses, or nurses, but males continued to be called charge attendants, second in charge attendants,

ordinary attendants, or temporary attendants” (McMillan, 1997, p. 31). In addition at this time, “nursing staff in prisons fall into two categories: prison officers who have specialized as health care officers with or without a nursing qualification, and registered civilian nurses” (Senior, 1998, p, 235).

*1950s.* In England, “up until at least the 1950s, health care was delivered by health care attendants” (Senior, 1998, p. 232). Even in 1984, England, Wales, and Northern Ireland still used trained health officers to deliver care to male inmates. For some reason nurses were hired to care for the women (Wool, 1995). In the 1950s, the Percy Commission in 1957 and the *Mental Health Act* in 1959, “led to a liberalization of psychiatric practice, de-emphasis on locked wards, a decrease in institutionalized care and a shift towards patient civil rights and the process of normalization” (O’Rourke, Hammond & Davies, 1997, p. 104). The *Mental Health Act* of 1959 gave courts authority to order offenders to hospital rather than prison, if they were thought to be in need of treatment. This treatment depended on the availability of suitable accommodation which was dramatically reduced in later years (Wool, 1995).

*1960-1970s.* The introduction of nursing into prisons and jails came about gradually with the recognition of the rights of offenders and their need for improved standards of health care. “The management of the asylums was transferred to the Department of Health and Social Services in the early 1960s” (Mason, 1999, p. 157). Of note, in 1965, England’s national policy of capital punishment was abolished. By the 1960-1970s, “forensic psychiatric nursing in England was practiced in the National Health Service, the special hospitals which provided services of maximum security, and in the prisons” (Blueglass, 1977, p. 53).

*1980s.* In the 1980s, “nursing in prisons was in a new growth era, major development in mental health provision, and changing health patterns in inmate populations influenced the evolution of specialized nursing services for prisoners” (Burrow, 1995, p. 29). In 1994, Health Care Standards for Prisons for England and Wales were approved by the Prisons Board which set prison policy. “The aim was for prisoners to receive care that was compatible with that offered in the general public by the National Health Service [NHS]” (Her Majesty’s Stationary Office [HMSO], 1994; Waring, 1996, p. 38).

*1990s.* The 1990s in the United Kingdom was marked by a series of public Inquiries (Department of Health, 1999; Her Majesty’s Stationary Office, 1992). The large “Special hospitals,” that housed the mentally ill offenders were repeatedly the focus of public scrutiny (Mason, 2000). The public inquiries may have proved to be most stressful to forensic nurses who were the primary providers of care, but had the least amount of authority to set or change policy.

*2000s.* By 2000 there were 50 forensic units across the United Kingdom (Robinson & Kettles, 1998), and the role of prison health nursing and forensic psychiatric nursing in the United Kingdom was well established. Male nurses in these roles were predominant compared to other countries like Canada and the United States. In addition, the United Kingdom had more of their forensic psychiatric nurses educated at advanced levels of education as evidenced by the publication and research by nurses in this area.

*Summary.* Strong, established roles of forensic psychiatric nursing were evident in the United Kingdom long before they appeared in other parts of the world. This was due to precedent setting laws like the insanity defence that brought about the placement of mentally

ill offenders into the care of the special asylums. *The Trial of Hadfield* in 1799 set a legal precedent for the “insanity defence”. Public reaction to the results of high profile cases shaped the law. One historical point which first put into practice minimal health standards in prisons was the *Health of Prisoner’s Act* of 1774 in England. “This law gave local justices the authorities to ensure health standards” (Senior, 1998, p. 231). While the origins of forensic psychiatric nursing can be located in the functions of the nineteenth century asylum attendant, the intervening years have witnessed a rapid and global development of the role (Mercer, Mason & Richman, 2001, p. 109).

#### *Globally*

*1940s.* Internationally, after World War II, the human rights movement influenced the care and treatment of many vulnerable and marginalized populations. The poor treatment of those in society with mental disorders led to the declaration of the *United Nations Universal Declaration of Human Rights* in 1948 (World Health Organization [WHO], 1978) and various documents like the declaration of the *International Covenant on Economic, Social and Cultural Rights*, 1976 which recognized the right of all to the highest possible standard of physical and mental health (WHO, 1978).

#### *United States*

*1800s.* Although Benjamin Rush has been attributed to being the “Father of American Psychiatry” in the early 1800s, American forensic psychiatry was founded in 1838 with the publication of Isaac Ray’s “Treatise on the Medical Jurisprudence of Insanity” (Quen, 1994). In the mid 1800s, “asylum based psychiatrists formulated model laws addressing involuntary commitment and debated the definition of mental illness for legal

purposes” (p. 1005). By the late 1800s, the courts became interested in findings of brain pathology in insanity defense cases, and neurologist joined psychiatrists as expert witnesses (Quen).

*1900s.* With the events of World War I and II, few changes occurred in forensic psychiatry and prison health care in the early part of the 20<sup>th</sup> century.

*1930s.* In 1930, medical services began to be provided in federal prisons, when the Narcotics Division of the U.S. Public Health Service (USPHS) became the Division of Mental Hygiene and authorized the public health service to provide medical services (Furman, cited in Hufft & Fawkes, 1994).

*Correctional nursing services in the U.S.* Subsequently, “nursing first began in the US federal corrections system in the 1930s when medical services began to be provided in federal prisons” (Furman, as cited in Hufft & Fawkes, 1994, p.36).

*1940s.* The National Mental Health Act in 1946 was the first of a series of legislative approaches designed to improve the care of the mentally ill and to enhance the mental health of the general population (Haber, as cited in Hufft & Fawkes, 1994). Also in 1946, “the first developed policy governing nursing activities in federal prisons was initiated by the United States Prison Health Services (USPHS)” (Hufft & Fawkes, 1994, p. 36). Historically, correctional mental health nursing arose from prison-based provision of health care to incarcerated inpatient populations.

*1950s.* By 1953, increased judicial activism led to new standards for insanity in criminal cases (*Durham Rule*), advances in the civil rights of mentally ill persons, and refinements in the role of expert witnesses (Quen, 1994).

*1960s. The Report of the Joint Commission on Mental Illness and Health* in 1961 highlighted “the deplorable conditions of mental hospitals” and recommended the establishment of community mental health facilities (Joint Commission on Mental Illness and Health, 1961). In 1964, the first matron was hired at the jail in Las Vegas. Prior to working in corrections Mary Hocker was an emergency room nurse at Southern Nevada Memorial Hospital. Gradually more female nurses were hired (Holly, 1972).

The civil rights movement in the 1960s created an awareness of the prisoner’s rights as a member of a minority and as an inmate (Felton, Parsons, & Satterfield, 1987). “Nursing’s interest in prison settings began to emerge concurrently with the social movements of the civil rights and anti-war movements” (Dubler, as cited in Felton, et al., 1987, p. 111). Following the civil rights movement and subsequent jailing of civil rights activists in the 1960s, “changes to laws resulted in the right to treatment, and a focus of attention on health care delivery within correctional facilities” (Bernier, 1986, p. 20).

*1970s.* In the 1970s, Chaisson (1981) concluded that “revolutionary changes in the organization and delivery of health care to inmates in prisons and jails came about due to class action suits by the inmates” (p. 737). Landmark Supreme Court decisions addressed correctional health care issues in the 1970s. Health care was recognized as a constitutional right, not a privilege (Dubler, 1979).

Moritz (1982) noted that the positive step forward: “for those incarcerated, health care was now thought that it should now be comparable to the standard in the community in which the correctional facility is located” (p. 253). U.S. courts declared that “failure to provide adequate health care to individuals confined in correctional institutions to be a

violation under the *Eighth* and the *Fourteenth Amendments*” (Droes, 1994, p. 201), thus a violation of their constitutional rights. Prisoners successfully accessed federal courts to apply constitutional rights to their conditions of incarceration. Thorburn (1995) noted in the case *Estelle v Gamble* [429 US97, 1976], the United States supreme court concluded that, “deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain,” in violation of the Eighth Amendment (p. 560). This landmark case and others that followed established health care as a constitutional right of correctional inmates.

In 1974, the American Nurses Association (ANA) passed a *Resolution on Health Care* in Correctional Institutions (Murtha, 1975). The American Correctional Health Services Association was founded in 1975, as a multidisciplinary membership organization comprising health professionals who work in correctional institutions (Thorburn, 1995). According to the American Public Health Association (APHO), in 1975, “a mandate by the courts for adequate and reasonable health care, resulted in professional groups establishing standards of health care for correctional institutions” (Felton, et al., 1987, p. 112).

“The American Medical Association (AMA) in 1978 published official documents specifying standards for health care services” (Felton, et al., 1987, p. 112). The American Board of Forensic Psychiatry was established in 1979 (Hashman, 1995). Changes in correctional health care that began in the late 1970s supported a role change for nurses.

Droes noted that “nurses became the major provider of primary health care in correctional facilities” (as cited in Felton, et al., 1987, p. 111). Murtha (1975) explained that “gradually the nurse moved from her pill-pushing role toward that of case finder, counselor,



group therapist and suicidologist, primary caretaker, and crisis intervener” (p. 422). A major change was that “finally nurses went behind security lines to give psychological and physical care to inmates locked in solitary confinement for days on end” (p. 422).

*1980s.* By 1981, “model health care delivery systems were designated, health care standards were developed, literature on correctional health care emerged, training programs were delivered, and conferences were convened” (Peternelj-Taylor & Hufft, 1996, p. 773). “In 1983, the goals of American prisons in 1983 were *care, custody and control or security, security, security*” (Alexander-Rodriguez in 1983, p. 116). Correctional nursing, received its own specialty status by the American Nurses Association in 1984, and the *Scope and Standards of Nursing Practice in Correctional Facilities* were approved (ANA, 1984). Correctional nursing is considered the oldest of all the subspecialties of forensic nursing. Bernier (1986) summed up the eighties well when she wrote, “At present the nurses who practice in the correctional system are a silent minority, it is rare that they publish in nursing journals and unusual for nurse educators to enlist their expertise in an effort to introduce this area as a practice option when considering career choices” (p. 25).

*1990s.* Forensic nursing was formally recognized as a distinct discipline during the 1991 Annual Meeting of the American Academy of Forensic Sciences in Anaheim, California (Lynch 1995b).

*2000s.* By the turn of the century, high profile cases were increasingly played out in the media. Although the public was made more aware of forensic psychiatric terms like insanity and mental illness, there was still a need for the public and professionals to be more

aware and educated regarding understanding mental illness and forensic issues in all countries.

*Summary.* The most influencing factors of the century for prison health care in the United States may have been the many human rights movements of the 1960s. Radical changes in the organization and delivery of health care to inmates in prisons and jails came about as the civil rights movement of the 1960s created an awareness of prisoners rights (Felton, et al., 1987). Health care for prisoners was recognized as a right, rather than a privilege (Cushing, 1986; Dubler, 1979; Moritz, 1982). American courts declared that failure to provide adequate health care to individuals confined in correctional institutions was a violation under the *Eighth and the Fourteenth Amendments* (Duber, Isele, as cited in Droe, 1994). Landmark cases established health care as a constitutional right of correctional inmates. By 2008, health care in prisons and forensic psychiatric issues became increasingly complex, with a shortage of qualified forensic health care professionals.

### *Australia*

In an Australian context, the philosophy and values of correctional functions trace their historical and cultural antecedents to the beginnings of the colonial penal settlement where they remained often impervious to many of the reforms and fundamental alignment of values in modern society. Historically, correctional mental health nursing arose from prison-based provision of health care to incarcerated in-patient populations. The locus of overcrowding and commitment pressures within prisons systems has ensured that nurses continue to share many of its less than optional conditions of their offender clients (Doyle, 1999).

“The growth of health based forensic units in Australia was assisted by a number of factors: labour governments in several states were more sympathetic to such developments; a burgeoning interest in civil and human rights throughout the country; coupled with a *Royal Commission into the deaths of Aborigines in Custody*, all greatly facilitated approval of the development of such units” (O’Brien, 1995). In the 1990s, the laws of the Australian Government recognized that a person’s capacity to access health services should not be compromised by reason of imprisonment and that all people have a basic right to health. This recognition was evident in Australia’s international treaty obligations” (New South Wales Health, 1997).

#### *Canada*

When Canada became a nation in 1867, health care was not recognized as an important responsibility of correctional services. In the late 1800s the mission of corrections was dual - to punish and to reform” (Calgary Remand Centre, 1996).

*1800s.* In 1835, Canada’s first penitentiary opened in Kingston, Ontario. *The First Penitentiary Act* was passed in Canada in 1868; and, Smale (1983) noted it was “traditional, military-minded and an essentially punitive approach to corrections” (p. 31). Canada’s criminal law was and is still rooted in the common law of England. The 1892 *Canadian Criminal Code* copied much of the *English 1878 Bill*. Arboleda-Florez, Crisanti, & Holley (1995) noted that “Canadian law on the mentally ill offender, as contained in the 1892 *Criminal Code*, remained practically unchanged for over 100 years” (p. 225). Early treatment of the mentally ill in Canada, similar to that in other countries, usually consisted of a jail term since insanity was not considered a health problem, but one of evil spirits or moral weakness.

In Western Canada, the Royal North West Mounted Police agency was responsible for providing correctional services. The NWMP surgeons coped with the insane by using available resources, which for them was a jail (Yonge & Osborne, 1991).

*1900s.* By the early 1900s, “the punitive approach in Canada eventually changed to a humanitarian approach” (Smale , 1983, p. 31).

*1950s.* With regard to the health care of prisoners, Lehmann (1983) wrote “in the 1950s, Canada adopted a similar system to the United Kingdom, early health care attendants were officers given extra training” (p. 37). In 1956, the philosophy of rehabilitation was adopted by Correctional Service Canada (Correctional Service Canada [CSC], 1996).

*Correctional nursing in Canada.* Up until the 1960’s, Lehmann (1983) recorded that the health care units in Canada were isolated and run by non-professionals. “Health care officers provided the minimum of health care, mostly first aid” (p. 37). They carried out a wide range of duties, such as medication administration, to control rather than to treat, the client. Smale (1983) added that any psychiatric services that were available focused on diagnosis not on treatment.

*1960s.* In the 1960s, male nurses were hired to provide health care in some of the correctional facilities and penitentiaries. In 1961, the *Second Penitentiary Act* was passed “bringing in health care reforms and a change to a more humanitarian philosophy” (Smale, 1983, p. 31).

*1970s.* In the early seventies, health care in Canadian prisons came under public scrutiny as social movements of the day were focused on human rights, civil rights, women rights, victim rights, and offender rights. In 1971, at the request of the Commissioner of

Corrections one of the earliest studies of prison nursing was carried out by a team of nurses. The results showed that nursing services in Canada were not systemized or standardized. Recommendations of the *McLean-Riddell Report* to the Commissioner of the Canadian Penitentiary Service, “suggested that all health care staff should be nurses, and female nurses should be also hired” (Smale, 1983, p.32). Policy changes resulting from the Commissions of Corrections Report allowed female nurses for the first time to work in correctional systems in Canada. The first female nurse was hired in late 1971 to work for (CSC) Correctional Service Canada at Drumheller Penitentiary in Alberta (Norens, 1971). Needless to say, the woman’s movement in society at the time was a major national and global influence.

In 1972, a national social policy mandated the abolishment of corporal punishment (whipping) as a punishment for disciplinary offences in federal penitentiaries. In 1976, capital punishment was abolished in Canada (Calgary Remand Centre, 1996). That same year capital punishment was reinstated in many states by the Supreme Court in the United States of America (Bureau of Justice Statistics, 2008).

By the recommendation of the *First Report* of the National Health Services Advisory Committee (NHSAC) in 1975, Health Services were established as a separate branch within the Penitentiary Service. In 1976, institutional health care centers and the delivery of personal health care to the inmates was the focus of the *Second Report* of the NHSAC (Smale, 1983).

Guidelines were established for professional conduct of health care personnel in 1977 (Lehmann 1983). Criminal background checks also began to be required on applications for employment. By the late 1970s, regional nursing consultants were introduced, policy

objective programs were enforced, accreditation or audits of health care units were mandated on a regular basis, problem orientating recording was introduced, and nurses working in corrections then required provincial registration (Smale, 1983).

*Forensic psychiatric nursing in Canada.* In 1972, the Advisory Board of *Psychiatric Consultants Report* estimated that “one in every 10 inmates in the correctional system required psychiatric care. They advised that the practice of putting psychiatric patients in the general population, or in segregation, protective custody or the infirmary to be totally unacceptable” (Smale, 1983, p. 32). The Advisory Board of the *Psychiatric Consultants Report* in 1972 recommended Penitentiary Services develop their own psychiatric services (Smale). As a result of the *Chalke Report* in 1972, three Regional Psychiatric Centres were established to provide in-patients and out-patients services to the inmates of Correctional Services Canada (CSC) and a fourth Regional Treatment Centre was established in the Atlantic Region (Conacher, 1993).

Forensic psychiatric nursing, formally appeared in Canada in the 1970s. The formal role of forensic psychiatric nursing essentially began in Canada when the mentally ill offenders were separated from the rest of the inmate population beginning in 1973 with the creation of forensic psychiatric services provided federally by CSC (Conacher, 1993). New roles for forensic psychiatric nurses evolved in Canada where forensic psychiatric units were established. In the 1960s-1970s, the improvements to prison health and mental health care services were attributed to: global attention to human rights, the failure of deinstitutionalization policies and the subsequent criminalization of the mentally ill (Kent-

Wilkinson, 1993), the increased rate of incarceration (Peternelj-Taylor & Johnson, 1995), and similar to the United Kingdom, the reaction to public inquiries.

Forensic psychiatric units were set up in forensic psychiatric service facilities in four major cities in Canada in the mid 1970s, Ottawa, Toronto, Montreal, and Calgary. Some services were delivered within general hospital settings and some in conjunction with Correctional Service Canada. The milieu therapy model as a treatment approach in Canada was emulated from the early forensic psychiatric units set up in the 60s in New York state. Nurses who worked on the forensic psychiatric unit in Calgary that opened in 1976 at the Calgary Remand Centre (L. Davis Registered psychiatric nurse, personal communication, September 20, 2001) stated they recalled the book by the Canadian forensic psychiatrist B. M. Cromier, entitled *The watcher and the watched* (Cromier, 1975) which provided a model for the Canadian Forensic Psychiatric units. Cromier had practiced in New York state and upon returning to Canada proved instrumental in the early years of forensic psychiatry in Canada.

*1980s.* In 1982, the *Canadian Charter of Rights and Freedoms* became a fundamental part of the *Canadian Constitution*. Section 7 of the Charter provided for “life, liberty and security of person”, while Section 12 ensures no “cruel and unusual punishment” (Department of Justice Canada, 2007). With the *Canadian Charter of Rights and Freedoms* being enacted in 1982 “many regulations in the *Criminal Code* contravened the mandates contained in the Charter” (Arboleda-Florez et al., 1995, p. 226; Department of Justice Canada, 2007), offenders were not only guaranteed the right to treatment but also the right to refuse treatment.

In the 1970s-1980s prisoners globally protested that the standard of health care delivered to them was lower than that received by non-prisoners (Sim, 2002). It is generally recognized that the greatest impetus for changes in health care delivery in the United States came from “the class action suits brought about by inmates” (Chaisson, 1981, p. 737) and similarly in Canada and the United Kingdom reactions to public inquiries and pressures of social movements of human rights leading to offender rights for health care. Court mandated policies for “adequate and reasonable” health care, resulted in professional groups establishing standards of health care for correctional institutions in many western-world countries. The introduction of nursing into prisons and jails came about gradually with the recognition of the rights of offenders and their need for improved standards of health care. Increasingly the belief of the level of education required of the health care professionals to provide the adequate standard of care to offenders was recognized to be more than the level of the army medic and first aid attendants.

*1990s.* In the early 1990s, health care reform was in various stages of development in Canada. Health-care personnel shortages, layoffs, and uncertainty affected the morale of nurses. In the 1990s, additional federal penitentiary facilities for women were opened across Canada due to the fact that Canada had only one federal facility for women in Kingston serving the entire country. The additional facilities came about due also in large part to the women’s movement of the 1970s and the urging of the Elizabeth Fry Society, an association that advocates for the human rights and needs of female offenders. In 1997, the mission of CSC emphasized secure custody, supervision, providing rehabilitation opportunities, and the protection of citizens (CSC, 1997b).



2000s. Health care was reorganized into health care regions and health authorities. A global nursing shortage meant that nurses had more opportunities to choose and make changes in their nursing roles. A general shortage of nurses for all nursing positions transferred into the same difficulty staffing registered nurses in roles in the jails and prisons at the turn of the century. The need for health care for offender population was most evident in the national health statistics. Prisoners most often were among the unhealthiest populations in any given country. Morbidity and mortality data have for years indicated that residents of correctional institutions experienced a higher rate of disease and disability than did the general population. Specifically, infectious diseases, chronic illnesses resulting from addictions, seizure disorders, mental illness, and rates of suicide occurred at rates higher than in the community (CSC, 2006).

*Summary.* In the 1970s-1980s prisoners globally protested that the standard of health care delivered to them was lower than that received by non-prisoners (Sim, 2002). It is generally recognized that the greatest impetus for changes in health care delivery in the United States came from “the class action suits brought about by inmates” (Chaisson, 1981, p. 737) and similarly in Canada and the United Kingdom reactions to public inquiries and pressures of social movements of human rights leading to offender rights for health care. Court mandated policies for “adequate and reasonable” health care, resulted in professional groups establishing standards of health care for correctional institutions in many western world countries.

The introduction of nursing into prisons and jails came about gradually over time with the recognition of the rights of offenders and their need for improved standards of health

care. Increasingly the belief of the “level of education” required of the health care professionals to provide the adequate standard of care to offenders was recognized to be more than the level of the army medic and first aid attendants.

#### *Forensic Psychiatry/Psychology--Education*

Although in some countries general psychiatrists can practice forensic psychiatry (i.e., Japan) most of the developed countries require a specific certification from the government to practice in this specialty area (Wikipedia, 2007b). In the United States, one year fellowships are offered in this field to psychiatrists who have completed their general psychiatry training. In Britain, psychiatrists are required to complete a three-year subspeciality training in forensic psychiatry, after completing their general psychiatry training, before they can be registered as a forensic psychiatrist. Forensic psychology is one of the fastest growing areas of psychology as suggested both by an increase in the practice of clinical psychology within the legal system and the increasing interest expressed by undergraduate and graduate students (Huss, 2001).

Robinson and Kettles (1998) noted that within disciplines such as psychiatry and psychology there were clear educational pathways available for those wishing to specialize in forensic care. However, for nurses, forensic educational tracks were not yet common. “Although there were elective modules at post basic level, they only skimmed the surface and did not prepare the student adequately to work in the forensic areas” (p. 214).

#### *Forensic Psychiatric/Correctional Nursing—Education--Clinical Placements*

1970s. Historically, schools of nursing had been less than responsive to the health needs of inmate populations in their education of nurses (Felton, et al., 1987). “The nursing

literature in the 1970s indicated that prisons were not often considered when nursing faculty chose sites for undergraduate clinical experience” (Fontes, 1991, p. 300). Even though the *ANA’s Position Statement on Psychiatric Nursing Practice* in 1967 validated the appropriateness of a prison as a learning laboratory (Bridges, 1981), it was not until the 1980s before clinical placements for nursing students in correctional institutions was commonly used and valued in Canada and the United States.

In the early 1980s, the literature began to cite the use of correctional institutions for student’s clinical learning experiences in community mental health nursing (Bridges 1981). “A correctional institution was used for a clinical learning experience by students in community mental health nursing at North Georgia, Dahlonega, Georgia in 1981” (Bridges, 1981, p. 744). “The University of South Carolina, College of Nursing’s community health nursing faculty initiated an affiliation with the South Carolina Department of Corrections in 1981” (Felton, et al., 1987, p. 112). Since 1980, in Alberta, Canada, the Calgary Correctional Centre’s Health Care Unit has provided students at the University of Calgary’s nursing program with an opportunity to gain practical, clinically based work experience in the correctional setting (Schlegal, 1984).

#### *Formalized Forensic Nursing Education in Colleges and Universities*

With the exception of SANEs, specialty education did not develop concurrently with role development for many of the forensic nursing subspecialties. Nurses for many years learned about their specialty on the job from those who worked with forensic populations of victims, offenders, and the deceased. Information about the specialty was not well communicated to nurses outside the forensic worksite. In the early 1980s, courses in

criminology and victimology became popular options for transfer credits towards a nursing degree for nurses with an acute interest in forensic areas. Criminology and victimology courses were the forerunner courses to forensic nursing program development. Once forensic nursing became a specialty that covered both areas of victims and perpetrators, formal courses were in demand.

The late 1980s and the early 1990s saw the beginnings of a variety of formal and informal educational programs being developed for nurses interested in the specialty of forensic nursing, including certificate programs and option courses for credits toward a degree. Although some courses or programs commenced in the 1980s, none if any were sustained. The Catholic University of America, in Washington DC was given a grant for a forensic psychiatric nursing course in the early to mid 1980s (Bernier, 1986); however, the course was only offered for one year.

By the mid 1990s, forensic nursing courses and programs began to be developed in a few areas in Canada and in the United States, which addressed all the subspecialties of forensic nursing who worked with victims, offenders, the deceased, and their families. An undergraduate classroom forensic nursing course ran for eight years beginning in spring of 1995, at the University of Calgary, Alberta, Canada (Kent-Wilkinson, 2006). By the mid nineties in the United States, face-to-face post-graduate level education began for forensic nurses with a forensic science focus at Fitchberg State College in Massachusetts in the east, and at Beth el College in Colorado in the west. About the same time there were specific forensic mental health and psychiatric courses delivered in the United Kingdom, Australia, and New Zealand (Kent-Wilkinson, 2006).

Considering that in 1995, the delivery of the first web-based course occurred in California (Bates & Poole, 2003), forensic nursing education began to make its online appearance on the global scene relatively quickly. Forensic nursing educators supported by progressive administrators, used the technology to offer the first online course of a forensic program beginning in January of 1997, at Mount Royal College (MRC) in Calgary, Alberta, Canada (Kent-Wilkinson, Mckeown, Mercer, McCann, & Mason, 2000). By 2001, at MRC a full certificate program of Forensic Studies was established with six courses online, and a sexual assault course (theoretical) was added soon thereafter (Kent-Wilkinson, 2006). Although Canada now has well established forensic certificate programs, Canada does not have forensic nursing graduate or doctoral programs. However, in the United States, Bader (2005) noted “four accredited universities offer doctorate level forensic nursing degrees” (p. 23).

### *Educational Levels*

By the end of the twentieth century, it was evident that an innovative movement toward forensic nursing was taking place internationally in every method of educational delivery possible. There were traditional classroom, distance, and Internet delivery with varying levels of certificate, diploma, baccalaureate, and graduate credit being offered. The following main levels of nursing education have established forensic nursing courses or programs.

*Certification.* *Certification* is an examination process that verifies whether a professional has a sufficient amount of current knowledge in a selected specialty area. Usually the professional organization in the field of study determines the criteria for certification and the length of time for which the certification is valid. Certification is

separate and different from a formal academic diploma or degree, neither of which guarantees qualification for employment in the area of practice. With regards to forensic nursing, certification already exists for some of its subspecialties: correctional nursing has certification examinations offered by the National Commission on Correctional Healthcare; the American Association of Legal Nurse Consultants provides legal nurse consultants with certification examinations; and the International Association of Forensic Nurses began offering SANE certification in 2001 (Kent-Wilkinson, 2006, pp. 793-794).

*Certificate program.* A certificate program is a series of courses in a selected specialty of professional practice (e.g., mental health, emergency, critical care, neonatology, and gerontology). After completion, the student has a certificate in a specific area of practice. A certification program is required in some areas of practice to obtain employment. A certificate forensic nursing program is a series of courses in the specialty of forensic nursing (e.g., forensic health studies certificate), and following completion, the nurse receives a certificate in specific areas of forensic nursing (Kent-Wilkinson, 2006, p. 794).

*Graduate degree nursing program.* A master's of nursing degree requires advanced practice nursing studies, which are beyond a baccalaureate degree in nursing and include graduate nursing courses. "Advanced Practice Nursing is the application of an expanded range of practical theoretical and research based therapeutics to phenomenon experiences by patients within a specialized clinical area of the larger discipline of nursing" (Hamric, 2000; Hanson & Hamric, 2003, p. 205). When studying for a master's in nursing, students may want to choose to focus on the specialty area of forensic nursing or forensic healthcare issues for their articles, projects, or thesis. A graduate degree forensic nursing program provides a

master's degree in the specialized area of forensic nursing study (Kent-Wilkinson, 2006, p. 794).

*Doctoral degree nursing program.* A Ph.D. nursing program of study (which culminates in a doctoral degree in nursing) requires studies beyond a masters degree in nursing. When pursuing a doctoral degree in nursing, students may want to focus on the specialty area of forensic nursing or forensic healthcare issues for their research or dissertation.

None of the previously mentioned levels of education guarantees obtaining employment in the area of forensic nursing practice. Currently, certification in forensic nursing is not required in most forensic nursing subspecialties to obtain employment, but due to the laws of supply and demand, as with many other nursing specialties, certification may be required in the future. Nurses, like most other healthcare professionals, may choose to take educational programs outside of their discipline. Many forensic nursing courses are designed for multidisciplinary study, and most of them are recognized within [other disciplines](#) (Kent-Wilkinson, 2006). Mason (2002) noted that nursing does not have absolute rights to the forensic specialty of study. Many other disciplines have a forensic specialty of practice, such as forensic medicine, forensic psychiatry, forensic psychology, and forensic social work; each of which follows the standards of practice and codes of conduct of its specific discipline (Kent-Wilkinson, 2006, p. 795).

### Forensic Nursing Specialty

In this section I identify important factors that influenced the specialty and educational development of forensic nursing. Areas I address are significant professional associations, social movements, public policy, technology advances, and the media power.

#### *International Association of Forensic Nurses (IAFN)*

In 1992, the International Association of Forensic Nurses was formed in Minneapolis, Minnesota, when 74 forensic nurses, the majority of whom were sexual assault nurses, came together with a vision of founding their own national association. However, some nurses in attendance were death investigators, or practiced with offenders rather than victims. All nurses present had been identifying themselves as forensic nurses. In addition, some of the forensic nurses were from Canada. Therefore, the decision was made at the assembly in 1992 to create an international association encompassing all areas of forensic nurses (Kent-Wilkinson, 2006).

#### *IAFN Forensic Nursing Specialty Recognition and Standards of Practice*

Due to the efforts of the IAFN members, forensic nursing was formally recognized in 1995, as a nursing specialty by the American Nurses Association (ANA, 1995), and the IAFN members soon after developed their *Forensic Nursing Standards, and Scope of Practice*, approved and published in 1997 by the ANA (ANA, 1997). Forensic nursing, different from most nursing specialties, was made up of many subspecialties. The establishment of this alliance may have provided more power to the group to overcome some of the barriers and issues of working with marginalized and/ or vulnerable populations.



### *IAFN--Mandate and Mission*

The IAFN is a professional association of registered nurses working in the medicolegal nursing arena, and whose purpose is to develop, promote and disseminate information about the science of forensic nursing. The IAFN works with other nursing organizations to set standards and it strives to foster growth and development of forensic nursing as an emerging area of nursing expertise. The IAFN also promotes the exchange of information about issues and the transmission of developing knowledge among its members and with other interested professionals (IAFN, 1993b).

### *Role of IAFN in Development of Policies and Standards of Practice*

In IAFN, clearly delineated standards of nursing practice inform professional nursing care and provide a framework for responsibility and accountability. The IAFN has begun to make a significant contribution to global policies for forensic nursing education. The *Sexual Assault Nurse Examiner Standards of Practice* (IAFN, 1996) and the *Forensic Nursing Standards and Scope of Practice* were both developed by the IAFN membership (ANA, 1997).

Forensic nursing certification became available in 2001 for the subspecialty of sexual assault nurses. On October 1, 2001, an IAFN resolution on terrorism called for worldwide support of nursing education that includes mass disaster preparedness (IAFN, 2001a). At the same time, an IAFN resolution on forensic nursing education called for the development and implementation of comprehensive forensic nursing content at all levels of formal nursing education (IAFN, 2001b). Also within this association, a specific council of educators met several times beginning in 2003-2004 to develop a core curriculum for graduate level

advanced practice forensic nursing. A general core curriculum was developed using the “Essentials of master’s education for advanced practice nursing” document as a guideline (American Association of Colleges of Nursing, 1996).

The IAFN encourages forensic nurses to acquire and maintain current knowledge in forensic practice (ANA, 1997). The forensic nurse may seek additional knowledge and skills appropriate to the practice setting by participating in educational programs and activities, conferences, workshops, interdisciplinary professional meetings, and self-directed learning, thereby embracing a lifelong learning policy. The IAFN has taken a leadership role in the health policy arena to take positions on national and international issues. IAFN nursing leaders have had the opportunity to participate in meetings about national policy regarding sexual assault victims and interpersonal violence (Kent-Wilkinson, 2006, p. 796).

### *Social Movements and Public Policy*

Social movements and subsequent governments’ social policies may have been the main factors for the specialty roles of forensic nursing to emerge. Far reaching reforms at the interface of the legal, criminal justice, and mental health systems, altered the social context of jail operations and consequently made it possible for nurses to become the primary providers of care throughout the justice system. Prison reforms of the 18<sup>th</sup> century, humanitarian philosophies, public health, and social movements for human rights resulted in a role for nurses in society to care for persons needing physical and mental health care. Changes to correctional health care that began in the late 1970s supported a role for nurses in the correctional system (Felton, et al., 1987), due to inmate rights to health care and their right to have qualified professionals to provide care for them.

Legislative policies mandating the improvement of health care standards had been the impetus for the emergence of many other subspecialties areas of forensic nursing. Forensic nurses became the primary provider of care not only for many of society's stigmatized offender populations, but also for at-risk populations of victims. When the role of the death investigator was first developed in the mid 1970s, the background training of nursing was determined to be the best preparation for this role (Lynch, 1993b). In addition, long waiting times for victims of sexual assault to see the physician in emergency departments provided the impetus for nurses to want to provide the necessary examination and follow-up counseling themselves in the emergency departments or in clinics (Kent-Wilkinson, 2006).

The establishment of forensic psychiatric/correctional nursing was closely linked to the correctional (prisons) system in the United States and Canada. By contrast, forensic psychiatric nursing in the United Kingdom was linked to the special hospitals. Similarly, changes in health care and the evolvement of forensic psychiatric/correctional nursing services in North America were brought about by reactionary events to public inquiries (Kent-Wilkinson, et al., 2000) and societal movements.

#### *Power of the Media--Forensic Science*

Sherlock Holmes, the fictional character created by Sir Arthur Conan Doyle in works produced from 1887 to 1915, used forensic science as one of his investigating methods. Conan Doyle credited the inspiration for Holmes on his teacher at the medical school of the University of Edinburgh, the gifted surgeon and forensic detective Joseph Bell (Wikipedia, 2007c).

Decades later, the comic strip, Dick Tracy also featured a detective using a

considerable number of forensic methods, although sometimes the methods were more fanciful than actually possible. In literary terms, the mystery novels of Nancy Drew was the impetus for the early baby boomer forensic interest (from my personal perception and memory) long before the *forensic* term first appeared in the TV series called *Quincy* that sparked the interest of the late baby boomers.

Due to high public interest, an array of forensic shows followed. Popular television series focusing on crime detection, including *CSI: Crime Scene Investigation*, *CSI: Miami*, and *CSI: NY*, depict glamorized versions of the activities of 21st Century forensic scientists. These related TV shows have changed individuals' expectations of forensic science, an influence termed the *CSI effect* (Wikipedia, 2007c).

Bader (2005) in the United States studied the social impact of current forensic science television programs. He found that “the media had increased the time devoted to the numerous child abductions and murders committed within the last six months in 2005” (p. 22). Bader noted that the number of public responses to the Crime Stopper’s Information Line continued to increase on a daily basis. These services and many others had been developed and were available for public use 24 hours a day. “Regardless of public perception, this ever-increasing, over-exposure of the public to violence, crime, and criminal behavior has lead to numerous social changes” (p. 23). By the later part of the 20<sup>th</sup> century the media became a significant force for public awareness of violence and basic information on mental health and illness. High profiles cases were, in effect, a trial in the media, and the high ratings of the programs showed that the public was interested and wanted this type of coverage.

## Forensic Nursing Issues

I identified in this section some of the important issues and concepts in the literature on forensic nursing. The main issues I included were: discourses in the literature (which included the use of the term forensic or forensics); questions about forensic nursing identity and conceptualization issues; skepticism about forensic nursing as a specialty; the debate of care versus custody; and perspectives of the unique knowledge of forensic nursing.

### *Discourse in Literature Regarding Forensic Nursing*

Forensic nursing historically had been characterized with diverse viewpoints and conflicting ideologies as it sought to be identified as a unique specialty. Discourse continued as forensic nurse leaders were challenged with incorporating the core knowledge concepts of forensic nursing into educational programs. As forensic nursing found its place in educational programs, new debates arose on how best to disseminate this unique body of knowledge and how to conceptualize it. Although it was recognized as a formal specialty in 1995 (ANA, 1995), questions as to its definition, identity, and specialty status continued to be debated in the literature.

### *Forensic/Forensics Term Discourse*

The terms *forensic* or *forensics* had meant a form of discourse, and generated debate with how the term has been used and/or misused. Influenced by the media over the years, the new term *forensics* evolved.

*Forensic.* The original term *forensic* was derived from *forensic* a Latin word for public forum or meeting place in the Roman era where legal disputes would have been argued or debated (Burrow, 1993). An early edition of Webster's Dictionary (1913/1998)

defined the word forensic as “belonging to the courts of judicature, or to public discussion and debate” (p. 584), while a recent online version added “argumentative rhetorical; relating to or dealing with the application of scientific knowledge to legal problems” (Merriam-Webster Online, 2003).

*Forensics.* When the popular television show *Quincy* coined the word *forensics*, professionals in the field felt the word was misused for the politically correct (PC) term for *forensic science* (Kent-Wilkinson, 1999b). Forensic science (often shortened to forensics) was the application of a broad spectrum of sciences to answer questions of interest to the legal system in relation to a crime or to a civil action. The use of the term *forensics* in place of *forensic science* could be considered incorrect; the term *forensic* is effectively a synonym for *legal* or *related to courts* from Latin: it means *before the forum* (Wikipedia. 2007d).

The question was whether or not *forensics* was a proper word used by itself as a noun, or misunderstood for the politically correct term *forensic* which is an adjective. Language specialists stated that the term *forensic* is an adjective, and therefore should be used with a noun, not as a noun, as in the example of forensic nursing, forensic crime scene, or forensic knowledge. Over time, the colloquial term of *forensics* seems to have worked its way into the language of postmodern culture. It is now so closely associated with the scientific field that many dictionaries include the meaning as cited above.

#### *Forensic Nursing Identity and Conceptualization*

Up until the early 1980s, forensic nursing was poorly viewed as a possible career choice. Working with offenders, or in morgues was not a high status position in the eyes of nurses in general, or the public (Kent-Wilkinson, 2006), both of whom would often comment

to nurses who worked with forensic populations: “Why would you want to work there?” “Can’t you get any other job?” (Kent-Wilkinson, 1993, p. 25). A few barriers had to be overcome before forensic nursing gained recognition and a more popular status. The biggest challenge was the image of forensic nursing and the stigma associated with working with marginalized groups. At first, nurses who worked with forensic populations did not identify themselves as *forensic nurses*.

Up to the mid-seventies, an analysis of the early literature written by nurses who worked in forensic areas (Holly, 1972; McNiff, 1973; Norens, 1971; Padberg, 1972; Protzel, 1972; Sullivan, 1969; Winstead-Fry, 1975) revealed that nurses referred to themselves as prison or correctional nurses, sexual assault nurses, death investigators, or psychiatric nurses who worked on forensic psychiatric units. Their self-identity as a *forensic nurse* was nowhere evident.

The identity of the term *forensic nursing* had its beginnings in the mid 1970s when nurses working in different areas of nursing began to identify themselves as *forensic nurses* because all worked with forensic populations. At this time nurses even in the same city were not aware that other groups of nurses with very different practices were also calling themselves forensic nurses. Nurses who worked on forensic psychiatric units, nurses who worked in emergency departments or clinics, nurses who worked in medical examiner or coroner offices, all began to prefix their roles as *forensic*, although their practices were very different (Kent-Wilkinson, 2006). Although some nurses worked with victims, others worked with offenders and still others with the deceased. The common element was that each area involved nursing practice of caring for populations that in some way interfaced with the law.

Sekula, Holmes, Zoucha, Desantis, and Olshansky (2001) noted that forensic nursing had been conceptualized differently in different countries. Forensic nursing in the United States was focused primarily on the victims, whereas forensic nursing in Australia, Canada, and the United Kingdom was centered on care of the offenders. In the United Kingdom the term *forensic* nursing was generally accepted in the literature in the mid-1980s to denote those who work with mentally disordered offenders in secure psychiatric services (Mason & Carton, 2002). Although care of the victim population in the forensic nursing role dominated in the United States, the victim role of forensic nursing did not appear in the United Kingdom until nurses began to claim a role as sexual assault examiners in the 1990s.

#### *Debates Regarding Forensic Nursing as a Specialty*

Questions of specialty status and identity by title or name of *forensic nurse* were intertwined. A question of forensic nursing identity or title posed often in the literature was: Could nurses call themselves *forensic nurses* because they worked with forensic populations, or did they need to perform a specific forensic role like evidence collection to call themselves forensic nurses? Correctional nursing, perhaps the oldest of all the subspecialties of forensic nursing, did not at first identify itself as forensic correctional nursing. Some nurses argued that correctional nursing did not have the forensic components to belong in this specialty group. Whyte (1997) in the United Kingdom believed that a nurse must contribute to assessment in the justice process to be called *forensic*. He also questioned whether correctional nursing belonged under *forensic nursing*, claiming that the forensic scientific role should constitute the forensic title, not merely the forensic population of offenders



served. The argument was that there was not enough of an investigative or evidence collection role in correctional nursing.

In addition, a debate arose over the true status of forensic psychiatric nursing as a specialty: some declared it a distinct role with unique requirements and responsibilities, whereas others believed that the profession needed to define further its nurse-patient relationship and develop more standardized formal training (Gudgeon, 2004). Although, the American Nurses Association had recognized forensic nursing overall as a specialty, forensic psychiatric nurses themselves sometimes questioned their status as a specialty and in fact saw themselves more of a subspecialty of *psychiatric nursing* than a subspecialty of *forensic nursing*. Some noted that adding the term *forensic* assured a formalized interface with the criminal justice system, which also brought with it a new set of expectations for the outcomes of psychiatric nurses' evaluations and treatment interventions (Maeve & Vaughn, 2001).

Mason and Carton (2002) noted that there was one point of uniqueness in the forensic nursing debate of whether generalist principles of professional working practices are merely being applied to a specific patient population; or whether there is a unique body of knowledge known as *forensic*. They stated that this one point of uniqueness, although difficult to define was highlighted in the literature as the contrasting aims of *caring and custody* (Mason & Carton).

#### *Care and/or Custody*

The *care or custody* debate was prominent in the forensic psychiatric/correctional nursing literature for many years. Core to the philosophy of the discipline of nursing was the philosophy of caring, where *care and/or cure* has long been the debate or the discourse. The

issue was that *cure* was seen more of as a medical concept that represented the medical or illness model prevalent in nursing throughout the earlier part of the century. Many authors noted that the central theme in defence of specialist practice for forensic psychiatric practice was usually found in the dichotomy of *therapy versus custody* or *care versus custody* (Burnard, 1992; Burrow 1991, 1991b; Mercer, Mason & Richman, 2001).

“The ideological intrusion of a disciplinary philosophy that is often at best incongruous, if not antithetical to the core values of nursing had generated problems for correctional psychiatric nurses” (Doyle, 1999, p. 35). The “humanistic values of the mental health system constantly clash with the security goals of the criminal justice system. Forensic nurses, often found it difficult to project a caring humanistic approach when security, a specialized component of the correctional institution, had to be constantly kept in mind” (Kent-Wilkinson, 1993, p. 26).

Ideologically, practice is situated at the interface of the mental health and criminal justice systems, combining the function of care with that of public safety. “This is inherently problematic with mental health care professionals having to place themselves in two every different and often competing roles, one of caring and nurturing and one of control and restraint” (Mason & Carton, 2002, p. 541).

Eventually in the forensic psychiatric/correctional nursing literature, *care and custody* became more prominent. As nurses, forensic nurses realized that they must keep the fundamental philosophy components of their profession as their guide to their practice. The discourse on forensic nursing produced a form of knowledge in which patients needed *care* as well as to be in *custody* (Sekula et al., 2001).

With regard to *care and custody*, Brennan (2006) conducted a needs analysis study of education needed for nursing and care officer staff at the Central Mental Hospital in Dublin, Ireland. He identified that there were two important issues that arose from this debate: first, how to achieve a balance between care and security, and second, how forensic nursing is different than mainstream psychiatric nursing. He recommended that further research needed to be carried out to investigate these topics.

### *Unique Knowledge*

Increased interest in nursing's unique body of knowledge has been particularly evident in the last part of the twentieth century, as seen by the growth in research undertaken from a nursing perspective, and by the numbers of publications which focus on the nature of knowledge and theory in nursing. These efforts have served not only to advance the discipline of nursing but also to challenge all nurses to articulate for themselves the theoretical foundations of their practice (Hayne, 1992). Similarly, with each specialty of nursing, leaders in that specialty have the responsibility to articulate the unique knowledge of that specialty, distinct from nursing in general.

The literature reveals that forensic nurses in every subspecialty have attempted to sort out what is unique about their subspecialties of forensic nursing. Robinson and Kettles (1998) performed a qualitative study that asked a sample of 72 staff members from 10 forensic units (from Scotland and England) eight questions relating to the role and training of forensic nurses. The aims of their study were: to describe the nature and content of forensic nursing; to identify the subtle differences between fundamental mental health nursing and the practice specialist care, i.e., forensic nursing; and to determine how forensic nursing

differentiates and contributes to multidisciplinary care (Robinson & Kettles).

Results of the study indicated “there is such a person as a forensic nurse and that there are subtle differences from the general psychiatric role” (Robinson & Kettles, 1998, p. 214). Some of the differences they found from other forensic disciplines were: the 24 hrs/365 days a year care, holistic care, coordinator of care, manager of the environment, responsibility for the safety of everyone on the ward, work to a professional code of conduct. The differences between forensic psychiatric nursing from mental health or psychiatric nursing were: the care of patients in a locked environment, the juggle of roles of therapist and gatekeeper, and the balance of care and custody. The two main distinctions between general mental health nursing and forensic nursing were the depth, quality, complexity and intensity of the therapeutic relationship over time and the level of security and control.

The researchers found that offending behaviours were often violent behavioural characteristics that demanded advanced professional competence. “Dilemmas were the balance of the need for security against therapy whilst moving patient toward rehabilitation and life in the community” (Robinson & Kettles, 1998, p. 217). Forensic psychiatric nursing’s contributions to the multidisciplinary team were that they provided a balanced holistic view to the care and needs of the patient, and they provided a link between disciplines, which was a pivotal role and central to communication. Forensic psychiatric nursing’s difficulties with the multidisciplinary team were that they felt they had “less influence, less status reflected in less pay, and less autonomy than other disciplines” (p. 217).

In the United Kingdom, Mason (2002) conducted a literature review and thematic analysis of role tensions of forensic psychiatric nursing. The purpose of this literature review

was to explore the emergent issues relating to the difficulties encountered in forensic psychiatric nursing. The rationale for the study was the paucity of research undertaken to identify the constituent parts of this professional practice. The results were the identification of a series of major issues, which were broadly categorized as negative and positive views, security vs. therapy, management of violence, therapeutic efficacy, training, and cultural formation. From the identification of these issues, six binary oppositions, or domains of practice emerged as a theoretical framework to develop further research. The binary oppositions were medical vs. lay knowledge, transference vs. counter-transference, win vs. lose, success vs. failure, use vs. abuse, and confidence vs. fear (Mason).

#### Research--Forensic Nursing Education

In this section I identified the research in the literature on the topic of forensic nursing education, the focus of my study. Before forensic nursing education appeared in the curricula of colleges and universities, there was a proliferation of studies with findings demonstrating the need for forensic nursing education. I will first address the research that documented the need for forensic nursing training and formal educational programs of study, followed by what the literature reported about factors that influenced its specialty and educational development.

##### *Need for Forensic Nursing Concepts in the Curriculum*

There was a paucity of nursing research on forensic nursing education in the literature. But as indicated, there was a proliferation of research on the *need* for forensic nursing education, especially in the area of forensic psychiatric/correctional nursing as evidenced below:

*1980s.* The 1980s saw several educational surveys and needs assessments for forensic nursing in many countries. In the United States, Graham and Gleit (1981) surveyed a sample of schools representing 40% of those with accredited baccalaureate programs. They reported that jails or security complexes were used by approximately one quarter of the sample groups for student experiences. However, of those responding, 82% indicated that there was no focus on inmate health care in the curriculum.

In the United States, a survey of 470 nursing schools by Moritz in 1982 revealed that “eight-two percent of those responding (189 of 231) did not include inmate health care in their curricula. Less than 20% reported didactic or experimental content related to prison populations” (as cited in Fontes, 1991, p. 300).

In Canada, an educational survey by Phillips (1983) showed that 61% of the sample of 147 nurses working in correctional institutions felt that they should have a special certificate beyond initial registration. “A majority of the nurses, 80%, agreed to the need for post-graduate courses for all mental health disciplines pertaining to the treatment of forensic psychiatric patients” (p. 41). The results of the survey also identified a need to educate the public regarding the mentally ill offender, and to convince politicians to allocate more funds for the provision of forensic psychiatric services (Phillips).

Attitudes of student nurses toward prisoners following their clinical placements were also studied. In New York, Werlin and O’Brien (1984) studied baccalaureate nursing students who experienced a clinical affiliation in a prison, and reported a significant positive attitude change toward prisoners, demonstrated through pre-test and post-test design methods.

In British Columbia, Niskala (1986) conducted a survey to determine the competencies and skills required, and to identify the forensic nursing content in the curricula of general nursing programs. “Thirty-four forensic nurses ranked 13 general competencies, and 122 enabling skills in terms of importance in their work situations” (p. 412). In this Canadian study, “nurses reported a need for more training on 66 of the 162 skills and competencies items” (p. 412). Furthermore, the nurses expressed a need for courses leading to formal qualification. On the basis of these findings, Niskala (1987) suggested that the expressed need for acquiring specific knowledge and skills may be met by in-service or continuing education courses.

In Texas, Gulotta (1987) examined factors influencing nursing practice and job satisfaction in a correctional hospital. Among the resulting recommendations was that the educational needs of the nurses working in correctional settings should be explored in order to adequately prepare graduates for the frontiers of the future in correctional nursing.

*1980s summary.* Although educational surveys in the 1980s identified a need for formal courses in forensic nursing (Graham & Gleit, 1981; Gulotta, 1987; Moritz, 1982; Niskala, 1986, 1987; Phillips, 1983; Roell, 1985; Werlin & O'Brien, 1984), the research did not result in the development of sustainable educational programs in the decade of the eighties.

Although it was not sustained, one exception was that the Catholic University of America, School of Nursing in Washington, DC was awarded a grant in 1983 from the National Institute of Mental Health “to prepare forensic psychiatric nurses as clinical nurse specialists at a graduate level to function in all areas of the correctional system” (Bernier,

1986, p. 21). The forensic course reportedly was designed as a sub-specialty for psychiatric nursing but survived only one year of funding. Psychiatric programs, although historically one of the first specialties in the school of nursing, have struggled as an important component of nursing curriculum (D. Shelton, personal communication, January 5, 2004).

*1990s.* Literature from the 1990s expressed the need for forensic nursing education as the specialty developed. In the United States, by 1990, a survey of forensic psychiatric facilities in all 50 states found that forensic psychiatric nurses supported the acknowledgement of forensic nursing as a distinct clinical subspecialty and sought special credentialing for practice. Given the complexity of the medico-legal issues involved in forensic treatment, the report indicated that advanced nursing preparation seemed warranted (Scales, Mitchell, & Smith, 1993).

In England, Byrt (1990) found that nurses required training in the nurse-patient relationship, listening skills, personal qualities, and self-awareness. Medium secure units in England supplied their own on-the-job training. Friel and Chaloner (1996) in the United Kingdom noted the need for additional education in the preparation of nurses who worked as forensic community nurses. The researchers found that further education was needed because nurses were increasingly required to conduct formal assessments and produce comprehensive and influential clinical-managerial reports. Robinson and Kettles (1998) conducted a qualitative study designed to ask a sample of staff from ten forensic units (in Scotland and England) eight questions relating to the role and education of forensic nurses. Their study found a lack of specialized education and non-existent career pathways.



2000s. Research done in the new millennium continued to advocate for the need for forensic nursing education at advanced levels. In addition, the need for in-service programs for forensic nursing in secure psychiatric services had become a growing concern internationally. Storey and Dale (2001) conducted an examination of the pre-registration preparation of nurses to work in secure environments. As part of the Nursing in Secure Environments project, commissioned by the United Kingdom Central Council, all pre-registration program providers for mental health and learning disabilities were contacted and invited to participate in this study. Findings indicated that practitioners were not adequately prepared for work in these specialized environments (Storey & Dale).

Baxter (2002), in the United Kingdom, conducted a descriptive study to investigate the perceptions of nurses who worked in a secure environment about their roles and skills. The findings suggested that nurses in these environments had a broad role and possessed a range of skills and personal qualities. Similarities with colleagues in generic psychiatric settings were identified, but further specialist skills and knowledge were perceived to be required within the medium secure environment. Pre-registration training was seen not to prepare nurses for the secure environment, because after registration, there was a perceived lack of structure.

Ewers, Bradshaw, McGovern, and Ewers (2002) evaluated the effect of psychosocial intervention training (PSI) on the knowledge, attitudes and levels of clinical burnout in a group of forensic mental health nurses in the United Kingdom. PSI was a relatively new innovation that helped clinicians to conceptualize their patients' problems within a more empathetic framework and trained them in the skills to intervene effectively. In their study,

thirty-three nurses working in a medium secure psychiatric facility completed questionnaires. The findings suggested that providing forensic mental health nurses with a better understanding of serious mental illness, and training them in a broader range of interventions, helped them to be more positive in their attitudes towards the clients that they worked with, and they experienced less negative effects of stress resulting from their caring role (Ewers, et al., 2002).

Rask and Aberg (2002) surveyed nurses working in five Swedish forensic psychiatric units to determine how nursing care could contribute to improved care, the organizational changes needed, and the knowledge nurses needed in order to be able to meet the demands in the future. The salient findings were: (a) an interpersonal patient-nurse relationship based on trust, empathy, respect, and responsibility for the patients' personal resources and knowledge seemed to be the essence of nursing care, and a way to improve care, and (b) the nurses' educational needs emanated from different treatment modalities: how to perform different treatments, how to establish developing relationships, and how to adapt in-service training to the ward-specific problems by first identifying the need for and benefits of in-service training.

The Rask and Aberg (2002) study found that the knowledge forensic nurses needed was specific content in 10 categories: nursing care, developing relationships, humanistic and basic human values, theoretical models and treatment techniques, psychopathology and medication, basic and further training, in-service training adapted to the ward-specific problems, documentation and evaluation, clinical supervision, and knowledge about other caring professions.

The IAFN Education Committee explored how to develop forensic health care information for use in undergraduate nursing programs. Typically, undergraduate programs of study were packed with required content that supported the students as they prepared for nursing board examinations. Programs allowed little flexibility for adding new content, despite the fact that the forensic content was in high demand. Forensic nursing was a specialty that students characteristically desired to pursue, but more important, “the information related to all areas of nursing practice, from pediatrics to geriatrics, from psychiatric mental health to the perioperative area” (Crane, 2005, p. 4).

Initially, the IAFN Education Committee discussed the best approach for integrating forensic content into undergraduate programs and the most efficient method of providing the information to students or to other faculty who taught it. Second, forensic information and case studies in content modules were discussed as a potentially useful tool for educators who had the desire but limited time in which to teach new content. The third step that the Education Committee took was to develop and refine a brief survey of IAFN members to determine if nurses were taught general and forensic nursing content and which forensic topics were included in their programs (Crane, 2005). “Of the 534 respondents to the survey, 338 (63.3% of them) were involved in nursing education” (p. 4). The statistical analysis delineated how many educators were teaching general and forensic content. “In addition, 202 faculty members provided continuing nursing education courses with forensic nursing content” (p. 4).

In the United States, a study by Maroney (2005), on the perspectives and expectations of correctional nurses employed in one New York State correctional facility, found there was

“a need to increase the educational preparation for correctional nursing practice, provide continuing education, decrease administrative bureaucracy, increase resources, improve working relationships with security, and increase respect for correctional nursing” (p. 157).

Brennan (2006) carried out a study to ascertain the specific education and training needs of a total target population of 101 staff members working at the Central Mental Hospital (CMH) in Dublin, Ireland, which provided national forensic psychiatric services. The results provided suggestions for how this service could provide appropriate education and training programs to address the specific training needs of staff working in that forensic specialist area, thus influencing changes in service delivery and the culture of the organization. The findings indicated that 51.5% of the target population in this service are employed as care officers and that 97% of the target population were hospital based. These findings showed that care officers were providing a significant amount of inpatient care. The education and training needs of this group differed from the psychiatric nurses somewhat, yet some overlap could occur in the delivery of inservice training courses. Examples were: first aid, prevention and management of violence and aggression, and facilitation skills for group work. Of the respondents, 48.5% reported that management was supportive and encouraged them to participate in further education. Specific skills, which were identified in this study, could be used to plan and structure a more appropriate inservice education and training programs for this service (pp. 175-183).

Findings from the Brennan (2006) study, suggested there was a serious lack of education and training facilities at that hospital. He noted that staff nurses and care officers in that service had an inadequate level of access to computer and Internet facilities, and that the

Internet should be available at a certain location accessible to all staff. One recommendation was that computers should be available on all units to bring that service up to date with many other services. For forensic nursing to develop as a specialty, Brennan believed it was vital that the particular skills and knowledge required are identified.

*Forensic Nursing Education--Research to Date*

There has been a paucity of literature to date on any theoretical or educational research on the current scope of forensic nursing educational programs. However, there was a study on the online delivery of forensic nursing education and a few studies on forensic multidisciplinary education.

*Online delivery research.* Since 1995, there has been a move toward web-based learning modalities for nursing education. In an increasingly technology-sophisticated world, it is important for nurse educators to take full advantage of this technology to enhance their learning. An study was done in Canada (Harvey, 1998) on the technology of online delivery of a forensic nursing program and reasons for taking the forensic specialty course. This study was on technical and content design characteristics, but not on forensic nursing content. The 1998 study found that most participants in the forensic online course surveyed chose to participate in the courses because of their interest in the subject matter. Over half of the participants chose the course because of the way it was delivered, which was innovative at that time. Personal enrichment and reasons related to career opportunities or enhanced current career status were most often cited as reasons for taking a forensic course at that time.

*Multidisciplinary/interprofessional training research.* Research findings on forensic psychiatric nursing and multidisciplinary training done in the United Kingdom offered

conceptual guidance or directions for educational course development in this specific focus of forensic nursing. Brooker and Whyte (2000), in a United Kingdom report aimed at multidisciplinary team-working in secure psychiatric settings argued that interprofessional training should take place at the clinical interface. They also added that it should focus on client-centered, problem-based learning exercises that allowed for reflexive learning.

Mason and Carton (2002) in their research undertaken to identify if common areas of multidisciplinary training in forensic mental health practice existed, did a review of literature and curriculum documents. They found that professional training took a diffused approach, with each profession formulating areas of study for appropriate *forensic* expertise, usually involving basic training pertaining to the profession followed by postgraduate studies. Mason and Carton advocated that this method of training was unclear and may not be appropriate. Thus it was necessary to identify what the required skills were to care for/ manage this patient population, as well as establish whether the skills were evidence-based and to what extent they could be measured.

An important finding of Mason and Carton's (2002) review was that the process was just as important as the content in the care/ management of mentally disordered offenders. The process was assisted by a knowledge base that was related to forensic practice and constructed from 13 broad multidisciplinary training areas: legal, assessment, treatment, evaluative, research, management, multidisciplinary, service development, risk, forensic, other, security, and ethical issues. Their model provided evidence to support common areas of multidisciplinary forensic training, and that specific training was required for staff to take action in these 13 areas (Mason & Carton).

*Forensic nursing education--student perspective.* In 2004, the members of the IAFN Education Committee resolved to address forensic nursing education for undergraduate nursing programs (Crane, 2005). Undergraduates at one university were asked what topics should be included in a generic undergraduate nursing curriculum if there was no option for forensic nursing courses. Respondents preferred that forensic content be spread out over curriculum, not blocked. They listed topics that they wanted: early warning signs of victimization and offending; communication between departments in hospitals and non-nursing disciplines including law enforcement, prevention, and intervention; sociocultural issues; a holistic view of family violence; information on the multidisciplinary team; more issues in pediatrics; and more knowledge on criminology. In general, nursing students exposed to forensic nursing wanted more information in all categories including more information on forensic nursing roles and responsibilities in general (Crane).

### *Gaps in the Literature*

The rationale for this study was provided by the gaps in the literature. The paucity of research on forensic nursing education, and exactly on what the knowledge of this specialty was, afforded the grounds to pursue this study. Because some educational programs have been established in the last ten years, I believed that it was a good time to interview educators in Canada and the United States, in order to explore from their perspectives what the unique knowledge was of this specialty, and what factors influenced the educational development of their programs.

My exploration of the literature identified significant gaps in the understanding of forensic nursing's unique knowledge required for educational development. The literature

reflected conflicting ideologies, complex roles, role tensions, and identity issues. Whilst there had been many research studies on the need for education and training in forensic nursing, there has been little research to date on the educational programs that are now available.

### Summary of Chapter Two

In this literature review I overviewed the origins of nursing and the history of forensic medicine and forensic psychiatry which provided the roots for the development of forensic nursing as a nursing specialty. I also addressed the evolution of the many forensic nursing subspecialties and the educational research done to date which had predominately stressed the need for education in this area. I discussed specialty and specialization as it related to the stages of specialty development, and addressed forensic nursing issues that have been debated in the literature. The influence of social movements, public policy, and the power of the media were identified as having an impact on the development of forensic nursing. Reviewing the relevant literature provided me with a framework for questions to explore, a focus to guide my research, and a solid yet flexible foundation on which to support the research design. I will provide in Chapter Three an overview of the research design, methodology and methods of data analysis that I used for this study.



## CHAPTER THREE

### THE RESEARCH DESIGN AND METHODOLOGY

In Chapter 3, I described how a interpretivist constructivist paradigm using a methodology of mixed methods was used to answer my research questions. The constructivist paradigm assumes “a relativist ontology (multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodological procedures” (Denzin & Lincoln, 2000, p. 21). Mixed methods as a methodology involves collecting and analyzing both forms of data (quantitative and qualitative) in a single study (Creswell, 2003). In Chapter Three, I described the basis of each methodology or approach, limitations and critiques, along with the sample, the setting, and the data collection methods. The steps used in a thematic analysis to identify, analyze, and report patterns (themes) within the data were also described.

#### The Purpose of the Study Revisited

The purpose of the study was to explore forensic nursing knowledge as a specialty area of study, and factors influencing educational development, as perceived by educators who were instrumental in the writing and teaching of the initial forensic nursing courses/programs. Forensic nurse educators were interviewed to gain an understanding of their perspective of forensic nursing, and how they conceptualized this specialty in their educational programs. Exploring forensic nursing as to its unique knowledge provided a starting place for inquiry. However, the goal was not only to describe *what is*, but to consider the larger socio-technical, media and economic forces that influenced the

educational development, and to link particular experiences into wider generalized and generalizing social relations. Therefore, I also examined factors influencing the educational development of the specialty.

### The Research Design

Research, according to Parse, in 1997 was “the formal process of seeking knowledge and understanding through the use of rigorous methodologies” (as cited in Barrett, 2002, p. 51). Hofer and Pintrich (1997) explained, “epistemology is a branch of philosophy concerned with the nature and justification of knowledge” (p. 88). The nature of knowledge centers on the question of “how we know what we know? What makes us believe that something is true?” Questions of this kind are epistemological in nature. The main methodologies and paradigms selected for this study are described in this section. The sampling, data collection, and data analysis based on this selection, together made up the research design used to explore the research questions.

### *Paradigm*

For this study I employed a constructivist and a mixed methods approach. Prior to discussing constructivism, I will address the term of *paradigm*. The term paradigm (created by Kuhn in 1962) are belief systems about questions of reality, truth, objectivity, and method that cut across disciplinary boundaries (Lincoln & Guba, 2000).

A paradigm or worldview, according to Denzin and Lincoln (1994) is the philosophical stance taken by the researcher that provided a basic set of beliefs that guides action or an interpretive framework. They further called this paradigm “the net that contains the researcher’s epistemological, ontological, and methodological premises”

(p. 13). Creswell (1998) also extended this *net* to include axiological and rhetorical assumptions. All these assumptions according to Creswell are related to the nature of reality (the ontology issue), the relationship of the researcher to the study being researched (the epistemological issue), the roles of values in a study (the axiological issues), the language of research (the rhetorical issue), and the process of research (the methodological issue). Guba and Lincoln (1994a) stated that a paradigm defines for its holder, “the nature of the world, the individual’s place in it, and the range of possible relationships to that world” (p. 107). My worldview, as the researcher of this study was from a constructivist paradigm.

### *Constructivist Paradigm*

The basic idea or roots of constructivism dates back at least a hundred years with much of the early work being done by John Dewey. Dewey (1933, 1938) stated that discourses in practice, education, and technology may not be an *either/or* debate, but rather *both/and*, and *it depends*. As an intellectual process, constructivism was built on assumptions that knowledge is not static; that people undergo change; and that contexts function to facilitate or hinder, or otherwise influence human goals and psychosocial processes (Creswell, 1998). Therefore, from the constructivist worldview, multiple perspectives exist, and multiple and alternative factors are recognized to have influenced practice, education, and research in positive ways in any discipline.

The constructivist paradigm of inquiry, as identified by Guba and Lincoln (1994a), perceives the nature of reality as a local and specific mental construction formed by a person, and holds that multiple mental constructions collectively exist regarding reality

(relativism). Therefore, the knower is subjectively and interactively linked in relationship to what can be known. Methodologically, “the researcher engages an inquiry process that creates knowledge through interpreted constructions dialectically transacted, thus aiming for more informed and sophisticated consensus constructions to provide a reconstructive understanding of a phenomenon” (Annells, 1996, p. 385).

Constructivist inquirers, according to Lincoln and Guba (2000) seek to understand contextualized meaning, to understand the meaningfulness of human actions and interactions as experienced and constructed by the actors in a given context. This aim is based on the assumption that the social world, as distinct from the physical world, does not exist independently, “out there,” waiting to be discovered by intelligent and technically expert social inquirers. Rather, Greene (2000) stated that the emotional, linguistic, symbolic, interactive, political dimensions of the social world, and their meaningfulness, or lack thereof, are all constructed by agentic human actors. “These constructions are influenced by specific historical, geopolitical, and cultural practices and discourses, and by the intentions--noble and otherwise--of those doing the constructing” (p. 986). So these constructions are multiple and plural, contingent and contextual.

I have been guided by my paradigm or world view of constructivism. Prior to adopting this philosophical stance, I considered and rejected both positivism and post-positivism. I addressed positivism, post-positivism and neopositivism under rational for constructivism.

### *Choice of Methodological Approach*

I sought to explore forensic nursing knowledge as a specialty area of study, from the perspective of educators who wrote and taught some of the early forensic nursing courses. Taking into account this emphasis on understanding processes, I considered three qualitative methodologies as offering an appropriate way forward: ethnography, phenomenology and grounded theory. Briefly, ethnography involves the description and study of specific human cultures (Agar, 1986, 1996); phenomenology involves a study that investigates a phenomenon in terms of lived experience and lived meaning (Creswell, 1998); and grounded theory is described as a way of thinking about, and conceptualizing data toward the goal of developing a theory grounded in the empirical substance of the social areas chosen for investigation (Strauss & Corbin, 1994).

Each of these qualitative methods would have been relevant to this study, and certain aspects of quantitative methods would apply. The decision of a mixed methods approach was based on my research question(s) and the aims or purpose of the study. Qualitative research attempts to uncover what needs to be learned and quantitative research seeks to determine the amount. Therefore, I decided I needed both for my study, because my research questions required the need to both explore and to explain.

To reiterate, the factors which influenced my methodological approach were: the aims of my study, the infancy stage of the event of forensic nursing education, and the perceived advantages and disadvantages of other methods that could be used to examine the phenomenon of interest. Given the aims of my study, no single method stood out as being able to provide full or adequate answers to enable to confidently draw conclusions

or sufficiently enhance the speciality's knowledge an understanding of the issues under consideration. Consequently, I adopted a mixed methodology of both qualitative and quantitative approaches.

### *Mixed Methods*

The mixed methods approach involves collecting and analyzing both forms of data (quantitative and qualitative) in a single study (Creswell, 2003). "Mixed method, mixed methodology research increasingly is an accepted approach employed to investigate organizational phenomenon" (Johnstone, 2004, p. 259). "The concept of mixing different methods probably originated in 1959, when Campbell and Fiske used multiple methods to study validity of psychological traits" (Creswell, p. 15).

Recognizing that all methods have limitations, researchers felt that biases inherent in any single method could neutralize or cancel the biases of other methods. Triangulating data sources, a means for seeking convergence across qualitative and quantitative methods was developed. From the original concept of triangulation emerged additional reasons for mixing different types of data. For example, the results from one method can help develop or inform the other method (Creswell, 2003).

"A mixed methods approach is one that employs strategies of inquiry that involve collecting data either simultaneously or sequentially to best understand research problems" (Creswell, 2003, p. 18). "The data collection also involves collecting both numeric information (i.e., on interviews) so that the final data base represents both quantitative and qualitative information (p. 20). For example, in the mixed methods approach, collection of both quantitative and qualitative data is often performed

sequentially. The researcher bases the inquiry on the assumption that collecting the diverse type of data best provides an understanding of a research problem.

Creswell (2003) explained that “the study begins with a broad survey in order to generalize results to a population and then focuses, in a second phase, on detailed qualitative open-ended interviews to collect detailed views from participants” (p. 21). In this study, I used a similar process for Phase I (an email survey to collect demographic and statistical information) and Phase II (a semi-structured interview by phone to collect qualitative data).

#### *Constructivism Interpretivist framework*

My theoretical approach in this study was constructivism. In this approach, Guba and Lincoln (1994b) explained that theory or meaning is understood as generated and **co-created** in researchers' interaction with the data. Theory is not *discovered* in the data, neither is theory *applied* to the data. Data and theory are not separate entities; instead, data are always products of prior interpretative and conceptual decisions (Guba & Lincoln). The results drawn from studies done from a constructivist approach are intended to be relevant in particular to the setting under study and to the research questions (Wachtler, Brorsson, & Troein, 2006).

In a basic form, constructivism is also called an interpretivist framework. This position recognizes that meaning is not something inherent in reality *out there* but is **constructed by the individual**. Research is not seen as finding things that are there, but of creating meanings. The theoretical and philosophical foundations of the constructivist and interpretivist traditions can be connected back to the works of Schutz, Weber, Mead,

Blumer, Winch, Heidegger, Gadamer, Geertz, Ricoeur, Gergen, Goodman, Guba, and Lincoln (Schwandt, 2000). The constructivist tradition is rich, deep, and complex. This complexity according to Denzin and Lincoln (2000) is “evidenced in the ethical and political implications of these perspectives” (p. 158).

### *Different Types of Constructivism*

Constructivism embodies two major perspectives: cognitive constructivism and social constructivism. In addition, radical constructivism and new constructivism are also described in the literature and provide additional understandings. I believe radical or new constructivism, and Dewey’s (1933, 1938) early principles of constructivism represents my research best; however, elements of all types of constructivism are relevant to this study.

*Cognitive constructivism.* Cognitive constructivism is based on the work of Swiss developmental psychologist Jean Piaget. Piaget's theory of cognitive development proposes that humans cannot be *given* information that they immediately understand and use. Instead, humans must *construct* their own knowledge. They build their knowledge through experience. Experiences enable them to create schemas or mental models. These schemas are changed, enlarged, and made more sophisticated through two complimentary processes: assimilation and accommodation (Chen, 2007).

Piaget's theory has two major parts: an *ages and stages* component that predicts what learners can and cannot understand at different stages, and a theory of development that describes how learners develop cognitive abilities (Chen, 2007). It is the [theory of](#)



development that is the major foundation for cognitive constructivist approaches to teaching and learning.

*Social constructivism.* Social constructionism or social constructivism is a sociological theory of knowledge based on Hegel's ideas and developed by Durkheim at the turn of the 20<sup>th</sup> century. It became prominent in the United States with Berger and Luckmann's (1966) book, *The social construction of reality*. The focus of social constructivism is to uncover the ways in which individuals and groups participate in the creation of their perceived reality. It involves looking at the ways social phenomena are created, institutionalized, and made into tradition by humans. Socially constructed reality is seen as an ongoing, dynamic process; reality is re-produced by people acting on their interpretations and their knowledge of it.

Berger and Luckmann (1966) professed that all knowledge, including the most basic, taken-for-granted common-sense knowledge of everyday reality, is derived from and maintained by social interactions. When people interact, they do so with the understanding that their respective perceptions of reality are related, and as they act upon this understanding their common knowledge of reality becomes reinforced. Since this common-sense knowledge is negotiated by people, human typifications, significations and institutions come to be presented as part of an objective reality. It is in this sense that it can be said that reality is socially constructed.

Within social constructionist thought, a social construction (social construct) is an idea which may appear to be natural and obvious to those who accept it, but in reality, it is an invention or artifact of a particular culture or society. The implication is that social

constructs are in some sense human choices rather than laws resulting from divine will or nature. This stance is not usually taken to imply, however, a radical anti-determinism (Wikipedia, 2007e).

In this study, I asked the participants many questions about creating the forensic nursing educational programs. This orientation implied as Creswell (1998) clarified that meaning was socially constructed by individuals through interaction with their respective worlds.

*Radical constructivism.* Radical constructivism holds that among several accounts or representations of an object, there may not be necessarily any one accurate or true representation. “Taken to the extreme, this leads to a rather unsatisfactory position known as relativism, all accounts or representations of an object are relative, and no one can be seen to be any better than the other” (Pidgeon & Henwood, 1997, p. 249). For example, that which is labeled *forensic*, or *forensic nursing*, can be understood or conceptualized in any number of ways, depending upon the frame of reference of the teacher/writer of the course.

From the constructivist epistemological position, all scientific knowing involves the (subjective) interpretation of meaning, and without this attempt to construct knowledge in the world, this knowing could not proceed. Certain influential developments within contemporary social science and psychology follow the philosopher Michael Foucault (Rabinow, 1984). “This position argues that subjectivity is symbolic and not merely representational, and often bound up with the operation of social processes of domination/subordination or power” (Pidgeon & Henwood, 1997, p. 249).

Interpretations of Foucault's work are commonly seen in writings of forensic psychiatry/psychology and forensic psychiatric nursing authors, as referred to in the Literature Review in Chapter Two.

*New constructivism.* *New constructivism* has also been aided by the emergence of a critical perspective on absolute knowledge in the physical sciences, culminating in the establishment of chaos theory. With chaos theory, "everything was subject to debate, and 'it depends' became the order of the day" (Bergquist, 1993/2001, p. 480). New constructivism adheres well to the early principles as described by Dewey (1933, 1938). As previously mentioned Dewey (1938) stated that discourses in practice, education, and technology may not be an *either/or* debate, but rather *both/and*, and *it depends*. In determining what the unique knowledge is that has created the forensic nursing specialty, many conceptualizations of knowledge may be equally important.

#### *Rationale for Constructivism*

A *constructivist* believes in multiple, experientially based, and socially constructed realities. In contrast, a *neo positivist* believes in an external and objectively verifiable reality. For the neopositivist, concepts emerge or are discovered, as if they were there to be found. The act of discovery is separate from that which is discovered. For the constructivist, however, concepts are made, fashioned and/or invented from data. What constructivists find is what they make. "For the constructivist, all human discovery is creation" (Sandelowski & Barroso, 2003, p. 797). The leaders in the forensic nursing specialty, like any new field of study played a significant role in shaping the identity, the concepts, and the value of the specialty. Many of the educators who participated in this

study were the early clinical practice leaders and pioneers in the forensic nursing specialty.

### *Rationale for Mixed Methods*

There is a venerable view that methodology is linked to the ontological and epistemological assumptions of the selected research paradigm, and that methodologies cannot be mixed (Guba & Lincoln, 1988). However, one of the voices to the contrary has been Patton, who in 1988 argued for a paradigm of choices in that paradigms should not assume to be rigid and fixed, that they are not prescriptive, but only descriptive, and that researchers should not have to choose between paradigms. Patton posited that different methods are appropriate for different situations and that wherever possible multiple methods should be used. Implicit in this statement is “support for mixing in a single study, different ways of thinking about data, indeed that both inductive and deductive ways of reasoning can be complementary rather than mutually exclusive data analysis tools” (Johnstone, 2004, p. 262).

The *paradigm debate* is a long-standing one. A dichotomy exists between qualitative and quantitative approaches, and many researchers now believe that both should be used in understanding social phenomenon (Johnstone, 2004). For the questions I wanted to answer in my research, I concluded that a mixed methodology was necessary.

A team of researchers studying nursing specialties to determine the value of specialized education had the following reasoning when deciding on a qualitative methodology. “If we wanted to study if a specialist or specialty was different or unique from a generalist or general areas, we might do a quantitative study where we could

measure or count the areas that were unique, different or additional to generalized knowledge” (Joachim, et al., 2003, p. 58).

In this study of forensic nursing education, because I wanted to explore forensic nursing knowledge from the perception of the educators, my study was predominately qualitative. However, I also wanted to know what the unique knowledge was of the specialty that was different from other specialties and demographic information about the educators and descriptive information about the courses they created to make inferences as to how backgrounds and partnerships may have influenced course development.

#### *Sample Selection Process*

Prior to describing the data collection process, I first address aspects of the sample selection process. Areas of sample selection included: type of sample, criteria for sample selection, sample size, decisions in sample selection, participant schedule, and setting.

#### *Sample Selection and Recruitment*

I recruited the participants through personal and professional contacts. Prior to the study, I had developed a database or list of forensic nursing programs available (See Appendix C1). The participants in this study were from a population of nurse educators who had been involved in forensic nursing education course development and teaching. Twenty participants were recruited from two countries: Canada and the United States.

The process of soliciting participants for this study began with contacting colleagues I knew who had written and taught forensic educational courses. My involvement in the International Association of Forensic Nurses since 1994 had resulted in communication over the years with many other nurse educators. Because the

development of forensic nursing educational courses was relatively new (only within the last 10 years) there were not many established forensic nursing programs, and I believed I was aware of all that were available. The Internet also validated an up-to-date resource of forensic nursing programs.

*Purposive sampling.* In this study, I used purposive sampling to ensure that I obtained participants who met my particular criteria. Purposive sampling is commonly used in qualitative studies. Participants are selected because of some characteristic or experience that they can bring to the study (Patton, 1990). Postpositivist, constructionist, and critical theory qualitative researchers, according to Denzin and Lincoln (2000), “employ theoretical or purposive, and not random, sampling models. They seek out groups, settings, and individuals where and for whom the processes being studied are most likely to occur” (p. 370). The downside of purposeful sampling may be that the data collected are limited due to these common critical attributes of the targeted group.

*Criteria for selection of subjects.* Participants in the forensic nursing education study needed to meet two common criteria. They had to have (a) developed, and (b) taught, at least one forensic nursing course. This criterion was chosen because participants needed to have had the process of conceptualizing what they saw as the definition, ideology, and unique knowledge of forensic nursing as they put together the courses for their students. To obtain informants who can provide information related to the research problem, the researcher needs to set criteria for sampling stemming from the fact that they share a common experience (Porter, 1998).

*Sample size.* In qualitative research there are no published guidelines or a test of adequacy for estimating the sample size required to reach saturation equivalent to formulas in quantitative research. Rather, in qualitative research the signals for saturation seem to be determined by investigators' proclamation and by evaluating the adequacy and comprehensiveness of the results (Morse, 1995). I believe my sample selection represented most of the earliest established programs.

*Decisions in sample selection.* The sample was limited to Canada and the United States to provide a feasible, economic, and cohesive sample due to the constraints of my doctoral dissertation. There was no risk for selection bias in this study because the earliest established programs were contacted. I limited my recruitment to programs that were established prior to 2004, cognizant many more have appeared in the last few years (See Appendix C1, Forensic Nursing Programs Internationally--Websites). All but one of the nurse educators who chose to take part in the study were previously known to me.

*Participation of subjects.* Participation in the study was voluntary and the nurse educators were contacted by email in early 2006. As the researcher, I provided an explanation of the study, to the participants, which included the purpose of the study, and any risks of participation (see Appendix A-1, Information about the Study). Participants had the opportunity to ask questions about the study before giving their consent. The potential participants were solicited with no obligation to respond either at the first contact by email or to the email survey. In addition, participants were made aware that there are no anticipated consequences for refusing to participate or to withdraw from the study.

Some of the early participants provided suggestions and comments about the study, which contributed to the process of the study and to the findings. One participant suggested a further question should be asked about the sustainability of the courses or programs. Also, I added a question on what was most and least satisfying about writing and teaching the courses. Both questions were added and proved to yield further rich and informative data.

*Costs and benefits to the participants.* I needed to consider the potential costs and benefits to the participants in the study. I anticipated the costs would mainly be the participants' time to participate in the email survey and phone interview, and possibly fear of having their views or courses evaluated. Being aware of these potential costs, I made it clear in the initial email contact and on the information about the research and consent form that the intention was not to judge or evaluate participants in any way, and that the purpose was only to explore all perceptions. Efforts were made so that each individual would feel that their contribution was valued. I was acutely aware of each person's schedule and therefore limited each interview to one hour.

With regard to the potential benefits, participants had the opportunity to contribute knowledge through a research study. Also, most participants stated they that were keenly interested in the findings of the study, because they too were interested in the collective views the research questions asked, and that they would look forward to receiving the executive summary of the final dissertation as promised.

*Participant schedule.* I kept a Participant Schedule of all the research activity so that I had an account at a glance of the dates of all events for this research process (i.e.,



date invitation to participate went out by email, date survey information was returned, date of interview scheduled, and date the signed consent was received). This process provided a record of the data collection process and allowed me to easily see areas that were still outstanding (See Appendix D1 for the Participant Schedule 2006). I arranged the time and dates of each telephone interview as soon as the educator responded to the email stating they would consent to participate.

*Setting.* This research endeavor took place in the natural setting of the participant's home or office, by email, and phone communication. The phone interviews were scheduled at a mutually convenient time for the participant and for myself.

#### *Research Question(s)*

I explored forensic nursing knowledge from the perspective of forensic nursing educators in North America, who developed and taught forensic nursing educational programs:

- What is forensic nursing knowledge as a specialty area of study?
- What factors influenced the development of forensic nursing education?

#### *Data Collection Process*

I collected data from multiple sources that included email survey questionnaires, courses documents of syllabus and units of study, interviews, and the literature review. To answer these two broad questions, I applied two phases of research: Phase I was a survey questionnaire of demographic questions (S1-24) by email), and Phase II, was a set of qualitative semi-structured questions (Q1-13) by a telephone interview.

### *Phase I – Email Survey of Demographic/ Descriptive Questions*

In Phase I, I contacted the participants by email. I initially sent an Email Invitation (Appendix A1), and Information about the Study (Appendix A2) to 20 participants to ask them to participate in the forensic education exploratory study. In the email I provided an introduction to the study and pertinent information about the study. I advised participants that the study had two phases.

Phase I was an email survey to collect demographic data and descriptive statistics (See Appendix B1 for Email Survey Questionnaire S1-21), and Phase II of the study was a Qualitative Phone Interview (See Appendix B2 for List of Semi-structured Questions Q1-13). I asked participants if they would be willing to participate by completing and returning by email a survey questionnaire that asked demographic information about themselves and information about the course(s) they developed (See Appendix B1a, and B1b). Their agreement to return the completed survey signified an agreement to participate in Phase I of the study.

#### *Email Survey*

In the email survey I asked the educators demographic and descriptive questions about themselves and the forensic courses and/or programs they developed. Because some educators developed single courses and other entire programs of forensic study, I asked for information of both in my study.

*Demographic questions.* The personal demographic questions I asked involved: country, state or province; highest academic level of education; number of years of clinical experience in nursing, and number of years of clinical experience in forensic

nursing; number of years of teaching nursing, and number of years teaching forensic nursing; forensic courses taken by educators, and forensic nursing courses taken by educators; where educators gained their knowledge of forensic nursing; and, the number of forensic nursing courses the educators developed? (See Appendix B1 for Survey Questions, numbered S1-8).

*Descriptive questions.* I asked the educators the following questions about the courses they developed: location of their forensic course/program (university, college, or community setting); academic level of the forensic course/program; if a needs assessment was done prior to course development; year their forensic course/program first offered; if a prerequisite course was required; if there was a clinical component to the course or program; and if the course or program was open to other disciplines? (See Appendix B1 for Semi-Structured Questions, numbered S9-21). The descriptive statistics in Phase I provided a background of information from which I could make inferences in the analysis as to how demographics of experience or education may have influenced their personal perceptions that came forth in the qualitative interview of semi-structured questions that followed in Phase II.

*Descriptive information labeling.* I identified the data responses by putting the letter “S” for survey question in front of questions (S1-S21) to distinguish them from the qualitative question numbers (Q1-Q13). I used the letter “P” to identify the 20 participants initially contacted for this study (P01-P20). Therefore, the email survey responses were coded (S1-P01) to indicate as an example, Participant #1’s response to the first Survey Question, and the qualitative phone interviews were coded (Q1-P01) to

identify Participant #1's response to the first Qualitative Interview question. A parenthesis was used to identify and reference all research questions used in the study, and the coding for the participants. Most of the survey data I collected were ordinal, categorical, or nominal data, from which groups could only be described and compared. I displayed the data in bar graphs and frequency distributions and table ranges, means and frequencies.

### *Phase II, Qualitative - Phone Interview*

I chose a telephone interview over face-to-face due to the geographical disbursement of the participants. I conducted all interviews by telephone from January to November of 2006. I arranged each interview at a time convenient to the participant and myself, and each interview took between 30 and 70 minutes.

#### *Semi-Structured Qualitative Questions*

In Phase II, I compiled a list of semi-structured questions from questions I had during my experience of forensic nursing course development in the mid to late 1990s. I had the opportunity in my study to ask the questions of other educators who had been through the same process and to gain a collective understanding.

Prior to the telephone interview, I emailed the list of phone interview questions to the participants so that they could preview the questions they would be asked, and have the opportunity to think about their responses to the questions in advance (See Appendix B2, Telephone Interview Semi-structured Questions).

If they agreed to be audio-taped in the telephone interview, they were to fax their signed consent to me (Appendix B4, Consent for Audio-taped Telephone Interview) thus

agreeing to proceed with phase II. Then I arranged a date and time for the interview by email, and contacted the participants on the designated date and time for the purpose of the telephone interview.

I conducted the interviews using a broad topic guide of semi-structured questions. In the telephone interview, I asked each participant questions about what forensic nursing was to them, how they conceptualized it, and what the philosophical base of their forensic nursing program was; and then I asked a series of questions to solicit their perception of the influencing factors that impacted course development? (See Appendix B2, Telephone Interview Semi-structured Questions).

Issue sub-questions in a qualitative study follow the central underlying question. They are created to address the major concerns and perplexities to be resolved, the *issue* of a study (Stake, 1995). Creswell (1998) added that issue sub-questions “typically are few in number and are posed as questions” (p. 254). The *issue sub-questions* for this study were the sub-questions of the main research questions of this study that asked about the knowledge of the forensic nursing as a specialty area, and are as follows:

*Forensic nursing questions.* The first broad exploratory question I asked of the educators was: What is forensic nursing? Some clarification was given as to definition and meaning. I then asked further specific questions that resulted in responses that overlapped, and provided rich descriptive data. How did you conceptualize forensic nursing in your courses of study? What was the philosophical underpinnings of your course or program? Is that philosophy the same or different from your general nursing program and why? What is the unique knowledge of forensic nursing? How is forensic

nursing different from nursing is general and different from other forensic disciplines? How did you gain your forensic knowledge to be able to write the courses, and if the words “forensic nursing” were included in the title of the courses you developed? (See Appendix B2 for Semi-Structured Questions, numbered 1-7).

*Factors influencing course/program development.* Here I explored some broad areas as to how certain factors influenced the course development process. The questions were: What was the most/least satisfying about developing and teaching forensic nursing courses? How did organizations (government, hospitals, professional organizations) foster/discourage forensic nursing course development? How did institutions of higher learning as an organization (universities, colleges, communities) support/oppose forensic nursing educational development? What were the social/media/ technological/ economic and political factors that impeded or facilitated forensic nursing educational development? Why were forensic educational course not developed sooner? What were the factors that facilitated/impeded the sustainability of forensic nursing course or programs? (See Appendix B2 for Semi-Structured Questions, numbered Q8-13).

*Clarification of questions.* With some questions I prompted respondents to elaborate or asked additional questions. I asked further questions depending on the response. The initial list of questions were frequently modified or clarified by inserting the anti or negative perspective to each question, as it was noted this naturally came out in most of the responses without prompting (e.g., fostered/not fostered, supported not supported, facilitated/impeded, sustained/not sustained, influenced positively or negatively, and unique knowledge/ not unique knowledge).

*Labeling qualitative questions and participants.* I kept the data collected from each participant in a separate electronic document, similar to the labeling of the survey questions. I labeled each participant according to the question number (Q1-13) and the participant number (P01–P20) in that P was for participant. The sequence of numbers P1-20 were not necessarily in order of being contacted or interviewed as this communication varied. The data extracts throughout the remaining part of this dissertation were the translated direct citations of the responses from the interviews, for example (Q1-P1).

#### *Transcription of Phone Interviews*

I contracted a research assistant to transcribe each of the phone interviews. The interviews were all transcribed verbatim. One interview audio recording was of such poor sound quality that transcription was limited; however some content was extracted from each of the questions.

Prior to sending the transcribed interview back to each participant by email attachment, I checked each transcription with the audio tape, and did any needed editing to ensure that the transcription was accurate. Upon receiving their interview transcription, interviewees were given the opportunity to review, add, delete, or make any editing changes if needed before returning their signed transcription release me. All 17 consents were obtained for the phone interview, and for the transcription release.

Within two to three weeks of the interview, I emailed the participants a file attachment copy of their telephone interview transcript along with a Transcript Release Consent (Appendix A5). Prior to signing the consent for the Transcript Release and

returning it by fax to me, participants had the opportunity to delete, alter, or add to any of their responses as appropriate.

An electronic file was kept on each participant's response to the survey and phone interview. The file was updated with the participants' changes after they had the opportunity to view it. Only two participants made any changes to the wording of their transcript which was emailed back to them. The remaining group signed the transcript release without any modification of the data.

#### *Instruments (Questionnaires)*

The instruments were a survey or questionnaire to collect descriptive statistics by email (See Appendix B-1a, Demographic questions, and See Appendix B1b, Course questions) followed by a semi-structured interview that I developed with suggested modifications from the participants added (see Appendix B2). I designed both instruments and included questions that I believed to be relevant to the study, based on my own experience as a forensic nurse educator.

*Email survey (Phase I).* The survey is the preferred method of data collection in quantitative studies. One of the problems of using surveys is that they heavily rely on the self-reporting behaviours and attitudes of the respondents, and could therefore be open to response bias and misunderstanding. In addition, surveys have limitations in producing in depth information and understanding (Creswell, 2003). In this study, I used the survey to support the findings of the interviews. The use of email for data survey collection is becoming preferred over other methods of mail or facsimile (Yun & Trumbo, 2000).



*Interview (Phase II).* The interview is a common qualitative tool for collecting data. The task of qualitative research is thought of in terms of “creating meaningful descriptions of what people share during interviews and other data gathering exercises” (Stratton, 1997, p. 117). This way of thinking does not deny that there is a reality, but it claims that, at least for some persons, it is more useful to think of research as negotiating ways of understanding.

A semi-structured interview (rather than a structured or open/unstructured) is a method of research used in the social sciences. Patton (1987, 1990) stated that semi-structured interviews are flexible, that new questions can be brought up during the interview as a result of what the interviewee says, and that the interview flows more like a conversation than a structured interview that has set questions.

The interviewer may have a framework of themes to be explored during an interview, or an interview guide that lists a pre-determined set of questions or issues. This guide serves as a checklist during the interview and ensures that basically the same information is obtained from a number of people. Yet, there is a great deal of flexibility. Moreover, within the list of topic or subject areas, the interviewer is free to pursue certain questions in greater depth. The advantage of the interview guide approach is that it makes interviewing of a number of different persons more systematic and comprehensive by delimiting the issues to be taken up in the interview. Logical gaps in the data collected can be anticipated and closed, while the interviews remain fairly conversational and situational. The weakness of this approach is that the interviewer flexibility in wording

and sequencing questions may result in substantially different responses from different persons, thus reducing comparability (Patton, 1987, 1990).

Semi-structured interviewing can also be less time consuming than unstructured interviewing because there are some limits or boundaries placed on the process. I knew in advance of undertaking the interviews that each interviewee's time would be limited, due to the demands of their roles. I also felt that semi-structured interviews reflected the adopted constructivist belief, in that, the *worlds* of the researcher and the researched can not be separated in a completely objective way.

The telephone interview technique was valuable because it allowed me to interview more people from various locations than would otherwise have been possible. It saved me time of travel for a face-to-face meeting. Disadvantages to this method were: missed opportunities to explore non verbal cues, and lack of potential for further rapport.

#### *The Interview from a Constructivist Perspective*

A general account of interviewing from a constructivist perspective was published by Stratton (1992), who described two ideas acquired from systemic therapy, which clarified the method. One idea came from Cecchin, who proposed a stance of curiosity where the understanding of the participants was endlessly fascinating. If the interviewer can project this attitude genuinely, the respondent would not feel interrogated or evaluated, but would respond openly. Another idea about this stance came from Sanderson and Goolishian, who stated that “a therapist [interviewer] should be a respectful listener who does not understand too quickly, if ever...” (as cited in Stratton, 1997, p. 123).

Meaning was created within an interview and it was then my task as the researcher to provide an account that was meaningful and helpful to other people. Constructivism, at least within the systemic framework, made a strong claim that alternative accounts could be added together to enrich our understanding, rather than multiple perspectives be assumed to be incompatible. This is what is called a *both-and* rather than a *either/or* position (Stratton, 1997).

Stratton (1997) stated that when research is based on interviews, the interpreter's position from a constructivist approach means giving up the idea that an interview is a way of finding out about some reality, by objectively recording the beliefs, attitudes or cognitive processes of a person. It is not just a matter of recognizing that the observer inevitably affects what is being observed, so that what is discovered is contaminated by the presence of the interviewer. It is that the material is created through the interviewer's involvement. Without the researcher, the phenomenon of the interview would not have happened.

Stratton (1997) also explained that I should not be just interested in describing the interview, that I need to use the interview to gain an understanding of some aspects of the thoughts or activities in the lives of the people involved. The interview is a context in which people will give accounts, and it is the task of methodology to enable me to use these accounts to say something useful about the chosen aspects of the participants' lives (Stratton). My position as a constructionist researcher was about creating meanings and understanding perceptions of events, rather than just discovering facts. From here, I

would interact with the research participants and then with the interview data in producing the research account.

### *Results of Data Collection Process*

In this process, I contacted the people on my list of the 20 known established programs; all but three responded to my email and consented to participate in the interview. One participant did not follow through with both phases of the study, but her phase I demographic statistics were included in the final analysis. There were 16 females and one male. Four female forensic nurse educators were from Canada and the remaining were from the United States.

The recruitment and data gathering process occurred simultaneously over approximately ten months in 2006. Although most participants were identified early in that year, I did not contact them at the same time, so that scheduling of interviews and transcription could be managed effectively.

### *Data Analysis Process*

In this section I describe how I analyzed the descriptive data from the survey in Phase I. In addition, I describe content analysis, concept analysis, and qualitative analysis generally, then the steps for my thematic analysis which was the primary mode of the analysis for this study in phase II.

### *Descriptive Statistics Analysis*

I analyzed the data from the survey utilizing descriptive statistics (frequency, ranges, means, count and compare). Pie and bar graphs illustrated the findings (See Chapter 4, Phase I, Email Survey). For most of the survey responses I compiled

frequency distributions of the educator's demographic data and course content information, then correlated them where applicable to data extracts from the qualitative interview in phase II of the data analysis. The views of the participants in this study about forensic nursing education were explored in the context of their geographic location, educational and clinical background, ideologies that their universities supported, and as well, their own theoretical opinions.

### *Content Analysis*

At some point in the analysis process I realized I was also doing a content analysis on some of the data I found interesting. For example, I noted the frequency of specific words found in the data (e.g., forensic as a prefix to 92 words). Also I noted other words were often used as a prefix in the data (e.g., unique, legal, specialty). I became aware that identifying and counting these words and conducting a superficial analysis of each was actually elements of a content analysis.

Content analysis is another method that can be used to identify patterns across qualitative data, and it is sometimes treated as similar to thematic approaches. However, content analysis “tends to focus on minute details, often provides frequency counts” (Wilkinson, as cited in Braun & Clarke, 2006, p. 98) and “allows for quantitative analyses of initially qualitative data” (Ryan & Bernard, 2000, as cited in Braun & Clarke, 2006, p. 98). Thematic analysis differs from content analysis, in that themes tend not to be quantified, although sometimes they may be (Braun & Clarke, 2006). Boyatzis (1998) suggested that thematic analysis could be used to transform qualitative data into a quantitative form, and subject them to statistical analyses. The unit of analysis in

thematic analysis according to Braun and Clarke (2006) tends to be more than a word or phrase, which it typically is in content analysis.

### *Concept Analysis*

In addition, I believe that prior to a thematic analysis, I also began, to some extent elements of a concept analysis on the definition of forensic nursing. A concept analysis is a process of examining written and unwritten sources of information on a concept to clarify its uses and meaning. It is the complex mental formation of the experience that occurs in creating conceptual meaning (Chinn & Kramer, 1995). According to Powers and Knapp (1990) "a concept is an idea or complex mental image of a phenomenon (object, property, or event). Concepts are the major components of theory" (p. 22) which is the connection between theory and concepts. As the purpose of my exploratory study was not to develop theory, I decided to focus on doing a thematic analysis.

### *Qualitative Analysis*

All qualitative analytic methods can be roughly divided into two categories. Within the first category, there are those methods tied to, or stemming from, a particular theoretical or epistemological position. Second, there are methods that are essentially independent of theory and epistemology, and can be applied across a range of theoretical and epistemological approaches. Thematic analysis, according to Braun and Clarke (2006) "is actually firmly in the second camp, and is compatible with both essentialist and constructionist paradigms within psychology, nursing, and many of the behavioral sciences" (p. 78). My research, I believe was in this second type that would be compatible with my constructivist paradigm.

### *Thematic Analysis*

The interview data were analyzed using thematic analysis. This process compared and contrasted the data to the published literature, and the quantitative descriptive statistics were used to help to support selected areas of the qualitative findings and the qualitative data was used to support the descriptive statistics. “Thematic analysis can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on, are the effects of a range of discourses operating within society” (Braun & Clarke, 2006, p. 77).

I analyzed the data from the qualitative semi-structured interviews manually. Atlas or Nudist was not used. I reviewed both these programs but decided that the analysis would at least first be attempted manually. In thematic analysis, a qualitative analytic method, one searches for themes or patterns; “it offered an accessible and theoretically flexible approach to analyzing qualitative data” (Braun & Clarke, 2006, p. 77). I found thematic analysis was useful to minimally organize and describe my data set in rich detail.

### *Steps of My Thematic Analysis*

In this section I describe the steps of my thematic analysis. The process of doing a thematic analysis has been described by many authors (Boyatzis, 1998; Creswell, 1998; Denzin & Lincoln, 2000; Tuckett, 2005) and follows similar sequencing and phases. For the purpose of my study I chose to follow the six phases of thematic analysis as described by Braun and Clarke in 2006 (See Table 3.0, Phases/Steps).

Table 3.0

*Phases/Steps of Thematic Analysis*

	Phases of Thematic Analysis Phase Description of the process (Braun & Clarke, 2006, p. 87)	Steps of Thematic Analysis <i>Forensic Nursing Education Study</i> Phase Description of the process
1.	Familiarizing yourself with your data: Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.	Familiarizing Myself with Data Preparing Data Familiarize by reading Field Notes (Initial ideas)
2.	Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating.	Generating Initial Codes Sorting data Collating systematically Data bases across datasets e.g., Key Words.
3.	Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.	Searching for Themes Patterns – Categories/Subcategories Database: Initial Themes (A-Z) Database: Descriptors (for Q1-13) Dichotomy Category Theme: Is or Is not, (Q1-5) Positive/negative theme (Q8-13)
4.	Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.	Reviewing Themes Descriptors - Typologies I-VI across entire data set (identified in Q1 and added to for each Q1-13) Tetralogy/Pentalogy, Thematic Map1 Demarcation theme in Q 1-5 Positive/negative Theme in Q8-13
5.	Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions.	Defining and Naming Themes Typology I-VI Tetralogy (Nursing paradigm) Pentalogy (Nursing process) Themes I-X
6.	Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating the analysis back to the research question and literature, producing a scholarly report of the analysis (Braun & Clarke, 2006, p. 87).	Producing the Report: Analysis of Each Question (Q1-13) Relevance to the Study Constructivism Connotations– not either/or but both/and depends on/ influenced by Comparison to Literature Findings/Recommendations Resulting in a construction or co-creation of knowledge, constructed definition.

To describe the process of my thematic analysis, I used the term *Steps*, rather than *Phases*, because I had already used the word *Phase* to describe Phase I and Phase II of



my mixed methods study. I understood that with any qualitative analysis, some steps occur simultaneously and repeat, and it was difficult at times to articulate which steps came first. However, I was able to relate to the order that Braun and Clarke (2006) adhered to, so I used their phases as my guide

### *Step One. Familiarizing Myself with the Data*

Step one involved preparing, sorting, and familiarizing myself with the data from the original participant files of their responses to questions Q1-13. While reading each participant's response to each question I made *field notes* and noted any information that might go in the *recommendations* of this study.

#### *Preparing the Data*

I made a file for each participant (P01-P20) with their responses from the telephone interview to Questions 1-13. As I had the interviews transcribed *word for word*, I prepared the data for analysis first by taking out any utterances (i.e., ums, you knows), and proper names that would identify the participant, or other people. Once the signed transcript release file was returned to me with changes or editing, I made this the final file for this participant. I then referenced each sentence or paragraph by the number of the question (Q1-13) and the code letter of the participant (P01-P20). There was no data from P04, P13, & P14, P18 (See Table 3.1. Step One, Familiarizing Myself with the Data).

Table 3.1.

*Step One, Familiarizing Myself with the Data  
(Preparing the data, familiarizing & field notes)*

P01	P02	P03	P05	P06	P07	P08	P09	P10	P11	P12	P14	P16	P17	P19	P20
Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q
1-	1-	1-	1-	1-	1-	1-	1-	1-	1-	1-	1-	1-	1-	1-	1-13
13	13	13	13	13	13	13	13	13	13	13	13	13	13	13	

Question 1.	What is forensic nursing?	Field Notes
Question 2.	How is it conceptualized?	Date recorded
Question 3.	What is the philosophical base of forensic course/ programs?	Ideas & Recommendations
Question 4.	What is the philosophical base of nursing program?	
Question 5.	What is the unique knowledge?	
Question 6.	How did you gain your knowledge?	
Question 7.	What were your units of study/course syllabus?	
Question 8.	What was most and least satisfying?	
Question 9.	How did organizations foster/inhibit?	
Question 10.	How did educational institutions support/block?	
Question 11.	What factors (social, media, etc.) facilitated/ impeded?	
Question 12.	Why courses not written sooner/ why were they written?	
Question 13.	What factors help to sustain programs/ demise programs?	

*Familiarization with the Data*

Prior to sorting the data I read through each of the participant's transcripts to become familiar with the data. Because the data responses would later be sorted by the questions, I wanted to record any ideas generated from the context of each entire interview into the initial *field notes*. Also I knew that this would likely be the last time I would read each participants' interview in its entirety.

*Field Notes*

I recorded field notes when reading through each participant's interview and noted the following points: if the response was something that I knew paralleled or compared to what was in the literature; or if the participant suggested recommendations

for future studies. I recorded my initial thoughts or reflections and also the thoughts I had about the study and the process at that point in time, which may or may not have been influenced by what I was reading. In my analysis, the *field notes* from each participant were placed into one file and categorized by each question number. Therefore, the field notes could be later reviewed for each question. Beside each field note, I recorded the date so that I could have a record of the progression of the ideas and theme development.

### *Step Two. Generating Initial Codes*

Step Two began when I had read and familiarized myself with the data, and generated an initial list of ideas about what was in the data and what I found was interesting about it. This step then involved the production of initial codes from the data. Step 2 involved sorting and collating the data across the entire dataset, and coding the data.

### *Sorting of Data*

I labeled a file for each Qualitative Question 1-13. I then separated the data from each of the 16 participants into Questions 1-13 files with only the responses for that question in each file. For example, the Question 1 file had only the responses to “What is forensic nursing?” from 16 participants.

### *Initiating Databases Across Entire Datasets*

I picked out Key Words and Descriptors from the dataset of all responses to each question. I recorded the initial and common “Descriptors”, Word Codes, and Themes in a database of A-Z and collated them by Questions 1-13. Ideas that came to mind at the time of reading I recorded in the Field Notes and Recommendations that I cataloged by

### Step Two, Generating Initial Codes

Q1 P01- P20	Q2 P01- P20	Q33 P01- P20	Q4 P01- P20	Q5 P01- P20	Q6 P01- P20	Q7 P01- P20	Q8 P01- P20	Q9 P01- P20	Q10 P01- P20	Q11 P01- P20	Q12 P01- P20	Q13 P01- P20
Participant		Data Responses Categories and subcategories IS / IS NOT or POSITIVE/NEGATIVE			Field Notes			Databases				
PO1					Ideas			Key Words				
P02					Recommendations			Descriptors				
P03								Initial Themes				
P04		n/a										
P05												
P06												
P07												
P08												
P09												
P10												
P11												
P12												
P13		n/a										
P14		n/a										
P15												
P16												
P17												
P18		n/a										
P19												
P20												

### *Coding*

Tuckett (2005) acknowledged that the process of coding is part of analysis as data were organized into meaningful groups. Coding in this respect was dividing the data responses from each question (Q1-13) into meaningful categories and subcategories. However, labeling the data (e.g., Q1-P1) is also referred to as coding. The data seemed to fall in obvious categories of descriptions and dichotomies (e.g., Is /Is Not and Positive and Negative). However, I recognized that my coded data differed from my initial themes, which were (often) broader.

#### *Step Three. Searching for Themes*

Step Three began after I had all the data initially coded and collated, and I had a list of Code or Key Words or descriptors identified across the dataset. I developed my themes in Step 3, where I made the interpretative analysis of the data. This step, as Braun and Clarke (2006) explained, “re-focused the analysis at the broader level of themes, rather than codes, involved sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes” (p. 89).

Essentially, I started to analyze my code or key words and considered how different codes may be combined to form an overarching theme. I used tables to help sort the different word patterns into themes. Then I started to think about the relationship between code words, between themes, and between different levels of themes. In this process the initial themes for each question emerged as well as the main descriptors that I labeled typologies.

The process of Step Three, Searching for Themes was grouping the questions into three areas that yielded different types of responses. Questions 1-5 were definition or descriptive responses (i.e., Is, Is Not, Is a combination of, Is the same as, and Is different from). Questions 6 and 7 were similar to questions in the email survey that were compared back to the descriptive statistics and Questions 8-13 generated dichotomy responses of *positive and negative* themes (See Table 3.3a. and Table 3.3b. Step Three, Searching for Themes).

Table 3.3a.

*Step Three, Searching for Themes:  
Grouping of Questions that yields similar patterns of responses*

<i>Number</i>	<i>Question</i>	<i>Grouping</i>
Question 1.	What is forensic nursing?	Question #1-#5 Categories of Description/ delineation/ “Is” and “is not” responses
Question 2.	How is it conceptualized?	
Question 3.	What is the philosophical base of forensic course/ programs?	
Question 4.	What is the philosophical base of nursing program?	
Question 5.	What is the unique knowledge?	
Question 6.	How did you gain your knowledge?	Question 6-7 Variation of / compare to email survey questions
Question 7.	What were your units of study/course syllabus?	
Question 8.	What was most and least satisfying?	Question 8-13 Categories of Positive/negative responses
Question 9.	How did Organizations foster./inhibit?	
Question 10.	How did educational institutions support/block?	
Question 11.	What factors (social, media, etc.) facilitated/ impeded?	
Question 12.	Why courses not written sooner/ why were they written?	
Question 13.	What factors help to sustain programs/ demise programs?	

#### *What Counts as a Theme*

Braun and Clarke (2006) stated that a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set. “A theme might be given considerable space in some data items, and little or none in others, or it might appear in relatively little of the

data set” (p. 82). So, my researcher judgment was necessary to determine what a theme was, because *keyness* of a theme is not necessarily dependent on quantifiable measures, but rather on whether the theme captures something important in relation to the overall research question.

Table 3.3b

*Step Three, Searching for Themes: (cont.)*

	Category	Subcategory	Field Notes	Data-base Descriptors	Database Descriptors Key Words A-Z Initial Theme
Questions 1-5	Definition Description	Question 1-5 “IS” and “IS NOT” responses similar responses to Question #1 <ul style="list-style-type: none"> <li>• is</li> <li>• is not:</li> <li>• is influenced by</li> <li>• is dependant on</li> <li>• is different from</li> <li>• is a combination of</li> <li>• is both/and</li> </ul>	Ideas & Recommendations	Patterns & Descriptors  Words used frequently  Typologies <ul style="list-style-type: none"> <li>• Forensic Prefix</li> <li>• Legal Prefix</li> <li>• Unique prefix</li> </ul>	Initial Themes Knowledge Themes <ul style="list-style-type: none"> <li>• Forensic nursing definition</li> <li>• Legal relationship</li> <li>• Needed knowledge</li> <li>• Unique Knowledge</li> <li>• Multidisciplinary</li> <li>• Conceptualization</li> <li>• Concepts to include</li> </ul>
Question 6-7	Descriptive Stats	Question 6-7 Variation email survey questions <ul style="list-style-type: none"> <li>• How gained knowledge?</li> <li>• Course Index (Titles)</li> </ul>			
Question 8-13	Dichotomy	Question 8-13 Positive/Negative <ul style="list-style-type: none"> <li>• Foster/ Non Foster</li> <li>• Support/ Non support</li> <li>• Facilitative/ Inhibitive</li> <li>• Sustaining/ Non Sustaining</li> </ul>		<ul style="list-style-type: none"> <li>• Forensic Population</li> <li>• Forensic Specialties</li> <li>• Forensic Care</li> </ul>	Influencing Factors Themes <ul style="list-style-type: none"> <li>• Dichotomy Theme</li> <li>• Positive and Negative</li> </ul>

### *Inductive/Deductive Approaches*

In thematic analysis, themes or patterns within data can be identified in one of two primary ways: in an inductive or *bottom up* way, or in a theoretical or deductive or *top down* way. An inductive approach means the themes identified are strongly linked to the data themselves (Patton, 1988, 1990). “Inductive analysis is a process of coding the data without trying to fit it into a preexisting coding frame, or the researcher’s analytic preconceptions. In this sense, this form of thematic analysis is data driven” (Braun & Clarke, 2006, p. 83). In my study, I believe for the most part my data was coded in an epistemological vacuum or without a theory of knowledge in mind. Braun and Clarke (2006) explained, “in contrast, a theoretical or ‘deductive’ thematic analysis is driven by the researcher’s theoretical or analytic interest in the area, and is thus more explicitly analyst driven” (p. 84). In the case of my study I believe the specific research themes evolved through the coding process (which fits with the inductive approach).

### *Semantic or Latent Themes*

Another important decision about the themes revolved around the “level” at which themes were identified: at a semantic or explicit level, or at a latent or interpretative level. A thematic analysis should focus exclusively or primarily on one level (Boyatzis, 1998). Therefore, using a semantic approach, I identified the themes within the explicit or surface meanings of the data, because as the analyst, I was not looking for anything beyond what a participant had said or what had been written. Ideally, the analytic process involved a progression from description, where the data have simply been organized to show patterns in semantic content, summarized, and



interpreted, where there was an attempt to theorize the significance of the patterns and their broader meanings and implications (Patton, 1990), often in relation to previous literature.

By contrast, a thematic analysis at the latent level goes beyond the semantic content of the data, and starts to identify or examine the underlying ideas, assumptions, conceptualizations, and ideologies, that are theorized as shaping or informing the semantic content of the data. I believe that the semantic approach in my analysis (represented by the descriptors or typologies) was a surface description of form and meaning, while the latent approach (final themes) identified the features that gave the particular form and meaning.

Thus, for latent thematic analysis, the development of the themes involved interpretative work, and the analysis that I produced was not just description, but was already theorized. Analysis within this latter tradition tends to come from a constructionist paradigm where broader assumptions, structures, and/or meanings are theorized as underpinning of what was actually articulated in the data.

#### *Step Four. Reviewing Themes*

I began Step Four with a refinement of the initial (candidate) themes. During this step, it became evident that some of my initial themes were not true themes (i.e., not enough data to support them or data too diverse), while other themes I collapsed into each other (i.e., two initially separate themes formed one theme, see Table 3.4. Step Four, Reviewing Themes).

Table 3.4.

*Step Four, Reviewing Themes*

Category	Subcategory	Field Notes Recommendations	Patterns / Descriptors Became Typologies	Key Words Became Initial Themes
Questions 1-5 below			Data Base A-Z	Data Base A-Z
Definition Description Delineation	• is:	Weight of the core concepts  History	Typologies (Quantitative facts re the data) • Forensic Prefix (92) • Forensics (noun) • Unique Prefix (11) • Legal Prefix (08) • Legal Relationship (17) • Forensic Population (21) • Forensic Care (05)	Knowledge Themes • Definition • Unique Knowledge • Needed Knowledge • Emerging specialty • Specialty Status • Multi Disciplinary • Significant Person • Benefits of Forensic Nursing Education
Dichotomy Differentiation	• is not: • is different from			
Influences	• is influenced by • is dependant on			
Constructivism Demarcation	• is both/and: • is a combination of:			
Questions 5-6 below Questions 8-13 below Dichotomy	Positive: best, foster, support, facilitate, promote, sustain  Negative: worst, block, inhibit, prevent, impede	Questions 5-6 below compared to the email survey	Tetralogy • (Forensic) Nursing Paradigm Pentalogy • (Forensic) Nursing Process	Influencing Factors Themes • Positive/ Negative • History • Significant Person

Also other themes needed to be broken down into separate themes. Step Four involved my checking if themes worked in relation to the coded extracts (Level 1), and the entire data set (Level 2), generating a thematic *map* of the analysis.

What counted as *accurate representation* depended on my theoretical and analytic approach of constructivism. In this step I reread my entire data set for two purposes. I first wanted to ascertain whether the themes *worked* in relation to the data set. The second step was to code any additional data within themes that had been missed in earlier coding stages. The need for re-coding from the data set was expected, because coding according to Patton (1990) and Braun and Clark (2006) is an ongoing organic process. At the end of this step, I determined what my different themes were, how they fit together, and what the overall story was that they told.

#### *Typologies that Manifested from the Data Analysis*

From the Database of Key Words, it was readily apparent that some words were used frequently, and that different words were used to describe certain concepts. I labeled this phenomenon a *Typology* which is defined as a classification of types, or the study of systematic classification of types. I believe that this identification was at the semantic theme level only, because my Typologies were patterns that described the data. They proved to be interesting quantitative facts about the data but did not go as deep as the themes in my interpretations.

#### *Forensic Prefix Typology*

It was obvious to me in the dataset that the word *forensic* was used frequently. In fact the term *forensic* was used as an adjective or prefix for 92 different words. It became evident that the forensic prefix was put in front of almost everything to do with this specialty area as a qualifier or an added descriptor, so that each concept was uniquely forensic. In Question 1, *What is forensic nursing?* the forensic prefix was used in front of

30 different words. This list or typology I started in the analysis of the data from Question 1 and continued for all 13 Questions. I compiled a table of all 92 words (See Chapter 5, Table 5.1, Typology I Forensic Prefix). This Typology I found in the initial data base of Descriptors and Key Words (See Appendix E4, database of Key Words).

### *Other Typologies*

Many other typologies became evident in the data that were of interest to me. All typologies initially appeared in the Database of Descriptors or the Database of Key Words and data of Question 1 “What is forensic nursing?” and continued to be noted and added to with each subsequent question 1-13. All typologies involved the different words or language the educators used to describe elements of the forensic nursing specialty. I believe that all the Typologies I identified were at the semantic level of a theme. The description was at the surface meaning of the data and did not go to a deeper in the interpretation of the meaning in the analysis, although there were some interesting comparisons to what was reported in the literature. The list of the typologies can be found in Chapter 5, Findings.

### *Pentalogy/Tetralogy*

Also, I saw in the data several direct and indirect references in the responses made to the Nursing Paradigm and the Nursing Process. I felt that these important nursing frameworks could be adapted to the specialty of forensic nursing. See Chapter One, for the definition of the terms of: *pentalogy*, used to describe the five concepts of the nursing process, and *tetralogy*, used to describe the four concepts of the nursing paradigm.

### *Step Five. Defining and Naming Themes*

Step Five began when I had a satisfactory thematic map of my data. At this point, I then defined and further refined the themes that I presented for my analysis, and analyzed the data within them. Braun and Clarke (2006) explained, “by ‘define’ and ‘refine’, they meant identifying the ‘essence’ of what each theme was about, as well as the themes overall, and determining what aspect of the data each theme captured” (p. 92). Braun and Clarke also advised that it is vital that one does not just paraphrase the content of the data extracts presented, but that one identifies what is of interest about them and why.

For each individual theme, I conducted and wrote a detailed analysis. As well as identifying the *story* that each theme told, I considered how it fit into the broader overall *story* in relation to the research question or questions, to ensure there was not too much overlap between themes. So it was necessary to consider the themes themselves, and each theme in relation to the others. As part of the refinement, I identified whether or not a theme contained any sub-themes. I considered sub-themes to be essentially themes-within-a-theme. They were useful for giving structure to a particularly large and complex theme, and also for demonstrating the hierarchy of meaning within the data. (See Table 3.5. Step Five, Defining and Naming Themes).

### *Knowledge Themes*

Most of the themes, I initially identified in Step Three were continually reviewed. As I analyzed each of the 13 questions I made a table similar to the template for the analysis of each question previously shown in Table 6.4. I added to and refined themes

with the analysis of each question. Each table provided a quick overview of the analysis of each question.

Table 3.5

*Step Five, Defining and Naming Themes*

Patterns/Descriptors Became (Typologies & Taxonomies)	Key Terms became Initial Themes
<b>Typologies</b> <ul style="list-style-type: none"> <li>• Forensic Prefix (92)</li> <li>• Forensics (noun) (9/16)</li> <li>• Unique Prefix (11)</li> <li>• Legal Prefix (08)</li> <li>• Legal Relationship (17)</li> <li>• Forensic Specialty (8)</li> <li>• Forensic Systems (7)</li> <li>• Forensic Population (26)</li> <li>• Forensic Care (5)</li> <li>• Forensic Roles (22)</li> </ul> <b>Tetralogy:</b> <ul style="list-style-type: none"> <li>• <i>(Forensic) Nursing Paradigm</i></li> </ul> <b>Pentalogy:</b> <ul style="list-style-type: none"> <li>• <i>(Forensic) Nursing Process</i></li> </ul>	<b>Knowledge Themes</b> <ul style="list-style-type: none"> <li>• Knowledge Delineation (Typologies)(Descriptors)</li> <li>• Knowledge Concepts to Include</li> <li>• Knowledge Demarcation (separation, boundary)</li> <li>• Knowledge Differentiated (degree of difference)</li> <li>• Knowledge Dual Roles (Unique Knowledge)</li> <li>• Knowledge Definition (Co-constructed/Co-created)</li> </ul> <b>Knowledge Development - Influencing Factors</b> <ul style="list-style-type: none"> <li>• Factors Influencing - Positive &amp; Negative</li> <li>• Factors Influencing - History</li> <li>• Factors Influencing - Significant Person</li> <li>• Benefits of Forensic Nursing education</li> <li>• Forensic Models/Framework</li> <li>• Forensic Overarching Meta Theory (Social Justice)</li> </ul>

By the end of this step I could clearly define my themes. One test of theme definition was to see whether I could describe the scope and content of each theme in one or two sentences. If not, further refinement of that theme was needed. Although I had already given my themes working titles, at this point at I started thinking about the names I would give them in the final analysis. Braun and Clarke (2006) advised that “the names need to be concise, punchy, and immediately give the reader a sense of what the theme is about” (p. 93). Some of the final Knowledge themes became:

Knowledge Delineation  
 Knowledge Demarcation  
 Knowledge Differentiation

## Knowledge Dual Knowledge Defined

With each analysis, I produced a table using the template designed in Steps One to Four of the thematic analysis. For each theme identified, I explained the relevance of the theme, and collected examples of data extracts, along with comparative statements from the literature. Then I interpreted the data in what I called “constructed connotations” of what I believed were the findings of each theme, by showing how the analysis or findings related to or were interpreted by a constructivism worldview.

### *Step Six. Producing the Report*

Step Six began when I had a set of themes, and involved the final analysis and write-up of the report. According to Braun and Clarke (2006), the task of a thematic analysis, whether it is for publication or for a research assignment or dissertation, is “to tell the complicated story of your data in a way which convinces the reader of the merit and validity of your analysis” (p. 93).

Braun and Clarke (2006) further advised that the write-up of the analysis should, “include data extracts, provide a concise, coherent, logical, non-repetitive and interesting account of the story the data tells, within and across themes” (p. 93). I believed that my write-up must provide sufficient evidence of the themes within the data to demonstrate the prevalence of the theme. I chose vivid examples, or extracts that captured the essence of the point I was demonstrating, without unnecessary complexity. The extract was identifiable as an example of the issue. However, my write-up as required in any thematic analysis provided more than just data. The extracts were embedded within an analytic narrative that illustrated the story I was telling about my data; and my analytic narrative

as needed went beyond description of the data, and made an argument in relation to my research question (See Chapter 5 for Findings).

In Step Six, I began to identify issues for further discussion that co-evolved from the data. I began to formulate what some of the implications for education, practice, theory, and future research would be as a result of this study. Also in Step Six, I began to note ideas that could go into general recommendations, and summary statements for the final report or last chapter of my dissertation (See Table 3.6. Step Six, Producing the Report).

Table 3.6

*Step Six, Producing the Report*

<i>Chapter</i>	<i>Data Analysis Steps</i>
Chapter 4	Analysis of Phase I – Email Survey Questions (S1-S24) Descriptive Statistics Analysis of Phase II –Qualitative Interview -Responses to Questions (Q1-13) Analysis Table for each Question as developed from the Figures in Steps 1-4 of the Thematic Analysis Relevance of category/ subcategory to the Study Data Extracts Literature Comparisons Constructed Connotations
Chapter 5	Findings Knowledge Themes & Factors Influencing Themes Relevance to the Study Data Extracts Comparisons to the Literature Constructivism Connotations
Chapter 6	Discussion, Recommendations & Conclusion Summary of Chapters & Findings Discussion Recommendations Implications for Theory, Practice, Education & Research Conclusion



*Reasons for Choosing Thematic Analysis as the Method of Analysis*

All qualitative analytic methods according to Braun and Clarke (2006) can be roughly divided into two camps. Within the first camp, there are those methods tied to, or stemming from, a particular theoretical or epistemological position. Second, there are methods that are essentially independent of theory and epistemology, and can be applied across a range of theoretical and epistemological approaches. Braun and Clarke (2006) advocated “thematic analysis is actually firmly in the second camp, and is compatible with both essentialist and constructionist paradigms within psychology, nursing, and many of the behavioral sciences” (p. 78). As a constructionist paradigm was the approach of my research in exploring forensic nursing education, thematic analysis was an appropriate fit.

*Reasons for Choosing a Constructivism Method of Thematic Analysis*

Braun and Clarke (2006) explained that thematic analysis can be an essentialist or realist method, which reports experiences, meanings, and the reality of participants; or it can be a constructionist method, which examines the ways in which events, realities, meanings, and experiences are the effects of a range of discourses operating within society.

Thematic analysis can also be a *contextualist* method, sitting between the two poles of essentialism and constructivism characterized by theories, such as critical realism. Critical realism, as an example, according to Willig in 1999, acknowledges the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and

other limits of *reality* (as cited in Braun and Clarke, 2006). From that account, Braun and Clarke (2006) stated thematic analysis can be a method that works both to reflect reality and to unpack or unravel the surface of *reality*. However, they emphasized that it is important that the theoretical position of a thematic analysis is made clear, because the theoretical position is all too often left unspoken (and is then typically a realist account).

Any theoretical framework carries with it a number of assumptions about the nature of the data, what they represent in terms of the word, *reality*. Braun and Clarke (2006) emphasized “A good thematic analysis will make this transparent” (p. 81). Doing analysis in this study was in fact making interpretations, and these interpretations were based on the multiple perspectives of the participants, and of my own as researcher. The multiple perspectives of the nurse educators were analyzed from the data gathered by an email survey of descriptive statistics and telephone interviews.

#### *Limitations and Critique of Constructivist and Qualitative Research*

All types of research have restrictions that the researcher needs to attend to. Limitations and critiques of qualitative research, in general, and constructivism specifically are addressed below:

*Interview data as qualitative data collection.* Pidgeon and Henwood (1997) cautioned that the gathering of interview data holds its own pitfalls for the unwary. Basic problems included: “failure to establish rapport with particular participants; inadvertently dominating sessions; asking leading questions; and becoming constrained by pre-formulated questions rather than adopting a more open ended-conversational style” (p. 258).

In all research studies, rapport is needed between the researcher and the subjects to disclose detailed perspectives about responding to an action or process. Establishing rapport via email can be difficult. However, with this study I knew most of the participants. Over the last two years I had alerted them either by telephone or in person (when I met them at a yearly conference) that I would be contacting them to do this study. If I had not seen them previously, I telephoned them first to tell them about my study and that I would be sending an email survey. I believe this communication helped to increase the overall participation rate.

*Generalizability.* Guba and Lincoln (1981) have noted that the common characteristics among participants affect the ultimate *fittingness* of the research. The concept of *fittingness* in qualitative research and generalizability in quantitative research refers to the extent to which findings could be applied to other situations, other than those from which they emerged (Beck, 1993; Guba & Lincoln, 1981). Here, I as the researcher had to be cognizant of generalizability, in that the ideas may be similar from an evolving community of scholars. I hope that findings from this study can be generalized to other disciplines with forensic specialties, and to other educational specialties and nursing specialties.

Limitations exist with the degree of generalizability also in qualitative research. Qualitative methods are often criticized in the sampling method if the samples are too small. In many studies, small samples may preclude generalizability of findings to other populations; however integrating the findings with other similar research studies reported in the literature can be useful for positioning the study within the knowledge of the

discipline (Hegyvary, 2002). “In this way smaller studies can contribute to theory that can be applied and evaluated in other settings and populations” (Ferguson, 2004, p. 20).

However, my sample of 17 participants provided a substantial size for this study. Twenty to 30 subjects is the number usually recommended for most qualitative studies (Morse, 1998, 1999). As the approximate number of established forensic nursing education programs was approximately 30 with news programs being added every year, I believe I included all of the earliest established programs in order to achieve the best representation.

*Researcher’s impact on the study.* Denzin and Lincoln (2000) warned that a limitation of most qualitative studies is the impact of the researcher on the research. Although there are advantages of bringing personal experiences to the research, I realized that my personal bias as a forensic nursing educator may well have presented the most significant limitation. I was aware that one common problem was separating the role of researcher from that of participant. In the analysis process, I attempted to guard against finding the themes I wanted to find, and coming up with preconceived ideas, codes, and themes before generating them through the data collecting and analysis process. Also, I was cognizant that the research results obtained in qualitative studies may be influenced by previous relationships between the researcher and the participants when we were known to each other.

I attempted to be cognizant of the problems that could result from my personal bias from my own experience as a forensic nurse educator. To avoid my biases I engaged in extensive sorting and coding of the data, and then identified the descriptors and themes

in the analysis process. Thus, it was important for me to identify biases (my own as well as the participants') or subjectivities rather than try to eliminate them, and to monitor how they may be shaping the collection and interpretation of data.

As the researcher, I needed to "acknowledge that research is value laden" (Creswell, 1998, p. 75) and therefore I needed to discuss openly values that shaped the narrative, that included my own interpretation in conjunction with the interpretation of the participants. I strived to understand the meanings the participants had constructed about forensic nursing education from their experiences. In addition, blurring of boundaries is a common critique of the researcher's impact on the study in most qualitative studies. The researcher's "ongoing relationship to, and interaction with the data can blur the boundaries between notions rooted in the researcher's knowledge and experience, and those communicated by the research participants" (Olshansky, 1996, p. 403). However, as previously stated, the constructivist approach (Creswell, 1998) recognizes the researcher's participation as an important part of the process.

*Over-emphasis on the individual.* A hazard of any inductive method such as the constructivist approach, according to Charmaz (2000) is over-emphasis on the individual. The constructivist approach leads to a style that emphasizes the active, reflective participant. Yet larger social forces also act upon this participant; therefore, the researcher needs to learn how these social forces affect the participant and what, if anything, the participant thinks, feels, and does about these forces (Charmaz). This limitation was one that this research did need to adhere to. The fact that the forensic focus was a popular new trend for courses attracted interest for institutions to develop courses,

whether or not they had the faculty with the expertise to do so. Partnerships and affiliations between clinical facilities and educational institutions also needed to be explored as to how they influenced course development conceptually. For this reason, I wanted to include the historical social process globally that facilitated and impeded educational course development.

### *Evaluation of the Research*

Creswell (1998) noted the final stage of the research process is for outside reviewers to judge the quality of the study. “Judgments are made about the validity, reliability and credibility of the data within the standard canons of scientific research” (p. 209).

*Validity.* Present-day technology allows the recording of raw material rather easily, but the task of the qualitative researcher is then to find ways of extracting the essential information from copious amounts of qualitative material. Qualitative researchers place great emphasis on validity, but this term will have different meanings depending on the paradigm being assumed (Stratton, 1997). “Validity to a constructionist paradigm is not thought of as corresponding closely to reality. Rather, validity needs to be defined in terms of shared meanings within certain kinds of discourse” (p. 116).

*Descriptive validity* refers to the factual accuracy of the findings of the data for a project, such as entering the correct sample size and characteristics, settings, and data collection techniques (Stratton). *Theoretical validity* refers to the researcher’s constructions of interpretation of the facts. Sandelowski and Barroso (2003) noted that *pragmatic validity* refers to the validity, utility, and applicability of knowledge (i.e., whether the techniques and protocol developed can be used in practical applications). The responsibility for

establishing validity in a study rests with the researcher. *Interpretive validity* was also important to this study. Four types of interpretive validity are: usefulness, contextual completeness, research positioning, and reporting style (Jones & Nelson, 2004). Therefore, “threats to validity are minimized through careful attention to interview techniques, transcription, and analytic processes” (Penrod, 2003, p. 828). After the researcher identifies the categories and subcategories, and begins to make conclusions about the themes, the literature is used for *supplemental validation*. The researcher references the literature to give validation for the accuracy of the findings or how the findings differ from or relates to the published literature (Creswell, 1998). In this study on forensic nursing education, after completing the data analysis I compared the key participants’ responses (data extracts) from each question to the literature thereby integrating the findings with similar issues and studies reported in the literature, thus positioning the study within the knowledge of the nursing discipline and educational specialties.

*Reliability.* Reliability has an important role in qualitative research. Stratton (1997) explains, “It can be a useful indicator if researchers are able to operate definitions in similar ways and are creating the same meaning within the data” (p. 116). Often, a person reading a report of the results is likely to want to know that it would be possible for a different researcher to have reached similar conclusions from the data. Just as the participants expressed how much they would be interested in the collective findings of the study, so too was I was interested in how the participants viewed the executive summary of this study’s findings.

*Credibility.* The credibility of the constructivist paradigm can come from adherence to any of the limitations already cited: clarity of research question, philosophical *fit* of research paradigm, clear boundaries, and, recognition of larger forces that can impact on the study. For this reason, my main research question in addition to exploring what constituted the knowledge of the specialty, I was interested in factors influencing knowledge development from the perspective of educators in the field. Similar responses of impeding and facilitating factors would give credibility to the study.

*Rigor.* I made every attempt to assure methodological rigor in this study. Guba and Lincoln's (1989, 1994b) authenticity study criteria could be used to appraise the scientific rigor of the study. Recruitment and retention of subjects proved not to be a concern due to prior professional relationships that I had with the nurse educators, and the easy access to them through email. Most of the educators stated they looked forward to hearing the results of this study that they participated in, because they were very interested to hear what other educators' perceptions were to the questions asked.

*Decision-making processes.* Design decisions, instrument decisions, and decisions made in coding, categorizing and comparing data were made throughout the life of the project. Mixed methods methodology was chosen over any individual qualitative or quantitative method alone. The semi-structured interview was selected over options of an open or structured interview design. A telephone interview was chosen over face-to-face to answer the qualitative questions of the study.

*Specific issue to be addressed.* I believed the specific issue to be addressed was the need to be clear with the participants that this research was not an evaluation of



their forensic educational courses, but rather the purpose of the research was to explore forensic nursing knowledge as a specialty area of study and factors influencing educational development. The purpose was not what conceptualizations or perceptions were right or wrong, or better or worse, but simply what the conceptualization were.

### *Ethical Considerations*

It is the responsibility of researchers to protect participants from unintended harm resulting from the research. The researcher has a moral and a professional duty to be ethical, even when research participants are unaware of, or unconcerned about ethics (Neuman, 2000). Prior to the recruitment and data gathering for this study, approval of the study was sought from the University of Saskatchewan Behavioural Research Ethics Board (Beh-REB). The Board operates in accordance with the Canadian Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, August, 1998 (Government of Canada, 2003) and the University of Saskatchewan Policies and Procedures for Ethics in Human Research (University of Saskatchewan, 2002).

The Canadian Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (1998, August) stated, “good ethical reasoning requires thought, insight and sensitivity to context, which in turn helps to define the roles and the applications of norms that govern relationships” (para. 8). The purpose of the ethical standards embodied in the University of Saskatchewan Policies and Procedures for Ethics in Human Research is not to limit research activities but to promote and facilitate the conduct of all research in ways that respect the dignity and preserve the well being of human research subjects (University of Saskatchewan, 2002).

### *Ethics Proposal*

The ethics proposal for this study was submitted in October, 2005, and approved in mid November, 2005 (See Appendix A). In the proposal the procedures in the project were detailed. Upon approval of the proposal, the data collection commenced in late January of 2006, and was completed in November of 2006.

### *Informed Consent*

Once the nurse educators had received the information about the study, agreement to participate was waived, because the act of completing and returning the email survey was their consent for Phase I. However, their written signature of consent was required prior to the telephone interview, because it was audio-taped. In Phase II, the informed consents with their signatures were faxed back to my office (See Appendix A2, Participant Informed Consent).

The consent form that participants were asked to complete for this study addressed the following points: the participants right to voluntarily withdraw from the study at any time, the central purpose of the study and the procedures to be used in data collection, the protection of confidentiality of the data and anonymity of the respondents, and the statement about the known risks associated with participation in the study.

### *Confidentiality and Anonymity*

Every effort was made to protect the participants' right to confidentiality and anonymity, although it could not be guaranteed due to the small sample size of known forensic nursing educators and their forensic programs. Pseudonyms were used when transcribing the phone interviews. Participants were asked to sign a formal consent for

release of data transcripts. Here, participants had the opportunity to add, delete, or alter their own information on the transcripts.

The nurse educators' right to ask questions and to withdraw from the study at any time was guaranteed and explained in the information about the study. An attempt was made to protect the participants' right to confidentiality by taking measures to carefully handle and store the data. The list of names, code numbers, and email addresses were stored in a locked file cabinet, and transcripts were stored in a separate filing cabinet. During the research process, data relating to the study was archived on my computer until the research project was complete. The transcription information will be deleted from my computer when the dissertation and related publications are in print. Findings were generalized in an attempt to ensure anonymity, as much as possible, and efforts were made to report only aggregate results, and to avoid using proper names in direct quotes.

#### *Role of the Researcher*

Frankel and Devers (2000) stated that research results obtained in qualitative studies are influenced by characteristics of the researchers, the context in which research relationships are formed, and whether and how effectively researchers document and reflect upon how their own characteristics and biases shape the research results. G. W. Taylor and Ussher (2001) added how it is not uncommon to read of themes *emerging* from the data (although this issue is not limited to thematic analysis). An account of themes *emerging* or being *discovered* is a passive account of the process of analysis, and it denies the active role the researcher always plays in identifying patterns/themes, selecting which are of interest, and reporting them to the readers.

Ely, Vinz, Downing, and Anzul (1997) noted that “the language of ‘themes emerging’: can be misinterpreted to mean that themes ‘reside’ in the data, and if we just look hard enough they will ‘emerge’ like Venus on the half shell” (p. 205-206); or as Braun and Clarke (2006) stated, “If themes ‘reside’ anywhere, they reside in our heads from our thinking about our data and creating links as we understand them” (p. 80). I created the links and themes from the data, from what I thought was most important, from my own past experience and interest in the area.

Researchers can never be completely neutral as Creswell (1998) explained: they carry their background, both experiential and theoretical, into every research situation. In regard to this study of forensic nursing education, I had the experience myself of developing several forensic nursing courses for four different college/universities. I brought this personal experience to the analysis. As the researcher it was important for me to identify biases (my own as well as the participants) or subjectivities, rather than try to eliminate them, and to monitor how they shaped the collection and interpretation of data.

As the researcher, I strove to understand the meaning nurse educators had constructed about forensic nursing education and their perceptions based on their experiences in writing and teaching forensic nursing educational courses. “The qualitative researcher does more than observe history, he or she plays a part in it” (Creswell, 1998, p. 75)

### Summary of Chapter Three

In Chapter Three I expanded upon the research questions outlined in Chapter One and revisited the purpose of the study. I provided my reasons for choosing a mixed methodology as the research design. As my study was predominantly qualitative using a constructivism approach, I discussed the limitations and critiques of this design, including instruments, validity, reliability, data collection, and methods of analysis. I discussed ethical considerations, including the informed consent and the participants' right to confidentiality and anonymity. Following ethical approval from the University of Saskatchewan in November, 2006 (See Appendix, A7), I used a constructivist approach to explore the educator's perceptions of the knowledge of forensic nursing and how specific factors influenced the development of forensic nursing education. I set the scene for the study by describing the context or data collection process. Also I included here in Chapter Three, the steps taken for the Analysis of the Descriptive Statistics and the steps taken for my Thematic Analysis.

## CHAPTER FOUR

### DATA ANALYSIS, PHASE I AND PHASE II

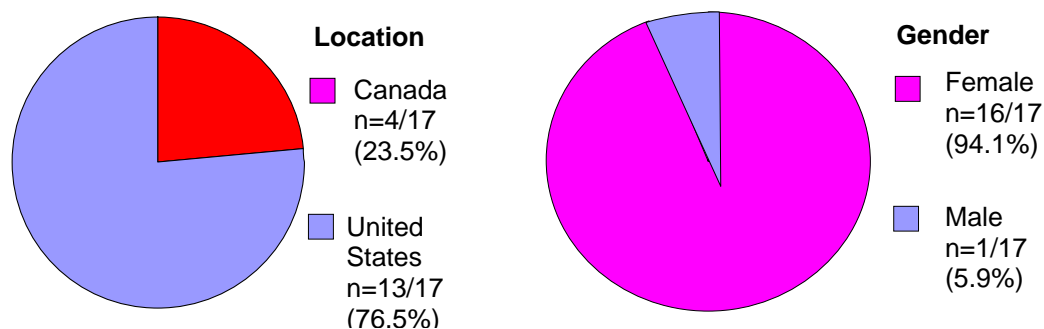
In Chapter Four, I provide an analysis of the email survey and the telephone interview responses. With this analysis, I began to explore the main research questions of this study: forensic nursing knowledge as a specialty area of study, and factors influencing its educational development from the perspective of nurse educators. The email questions are identified with an “S” for survey in front of the number of the question, and the interview questions are identified with a “Q” for qualitative in front of the number of the question. To facilitate reading, I identified the questions in bold text. Where applicable, I inserted aggregate data extracts from the interview responses into the analysis of the email survey analysis to support the findings, and visa versa in the interview analysis. At the end of each phase, a summary can be found of the analysis.

#### *Phase 1a. Analysis of Email Survey--Educator Demographics (S1-S8)*

In Questions S1-8 of the email survey, demographic data about the participants were collected. The analysis was highlighted under each survey question.

#### ***S1. Location and Gender***

The participants of this study represent nurse educators from the United States, and nurse educators from Canada. Of the 17 participants, 13 were from the United States, and four from Canada. Due to confidentiality issues, the state/province data was not included here. Of the 17 participants, there were 16 female and one male (See Figure 4.S1).

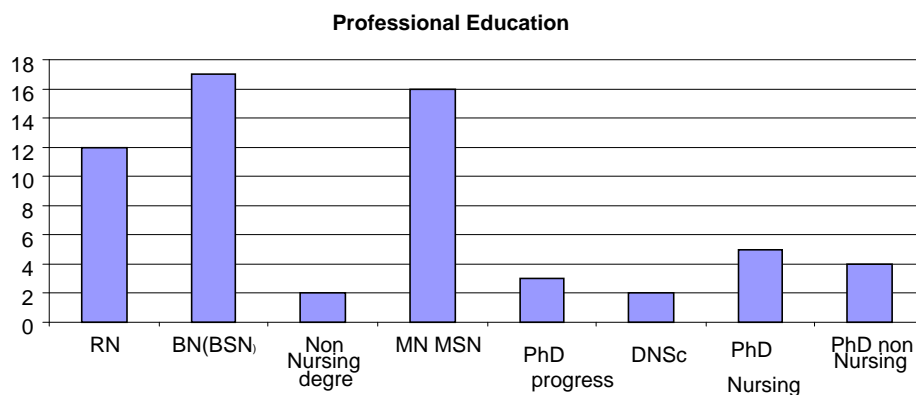


*Figure 4.S1*

Location and Gender

### ***S2. Highest Level of Education Achieved***

The analysis showed that the participant's highest level of education preparation ranged from baccalaureate to doctorate. Of note, all the 11 doctoral prepared educators were from the US. Of the three doctoral candidate educators, two were from Canada; of the two master's prepared educators, one was from each country; and, finally there was one baccalaureate prepared educator from Canada. The highest level of education achieved became significant later in the analysis when correlating aspects of this finding with S7 current position, and with the qualitative responses in the *influencing factors* theme. (See Figure 4.S2.).



(Diagram above shows all degrees achieved by participants)

Country	BN/BSN	MN/MSN	PhD (c)	PhD (DNSc)
Canada	n=1/17 (5.9%)	n=1/17 (5.9%)	n=2/17 (11.8%)	n=0/17
United States	n=0/17	n=1/17 (5.9%)	n=1/17 (5.9%)	n=11/17 (64.7%)
Range:	BN to PhD			

*Figure 4.S2*

Highest Level of Education Achieved

### ***S3. Number of Years of Clinical Experience in Nursing and Forensic Nursing***

Participants were asked to approximate the number of years they had of direct clinical experience in nursing, and subsequently to estimate the number of years of direct clinical experience they had in forensic nursing. (See Figure 4.S3).



### Direct Clinical Experience

<i>Years of Clinical Experience</i>	<i>Nursing</i>	<i>Forensic Nursing</i>
0-4 years	n= 2/17 (11.8%)	n= 3/17 (17.7%)
5-9 years	n= 1/17 (5.9%)	n= 3/17 (17.7%)
10 years and over	n=14/17 (82.4%)	n= 11/17 (64.7%)
Range	1-35	1-29
Mean	19.34	14.12

*Figure 4.S3*

#### Years of Direct Clinical Experience

The range of the 17 participants' clinical experience in nursing practice was 1-35 years, whereas the participants' clinical experience in forensic nursing practice ranged from 0-29 years. Many of the participants said they felt all of their general nursing experience was somehow related to forensic nursing, in that there were forensic aspects to all areas of practice. Examples of data extracts from the qualitative interview with regard to direct clinical nursing experience were:

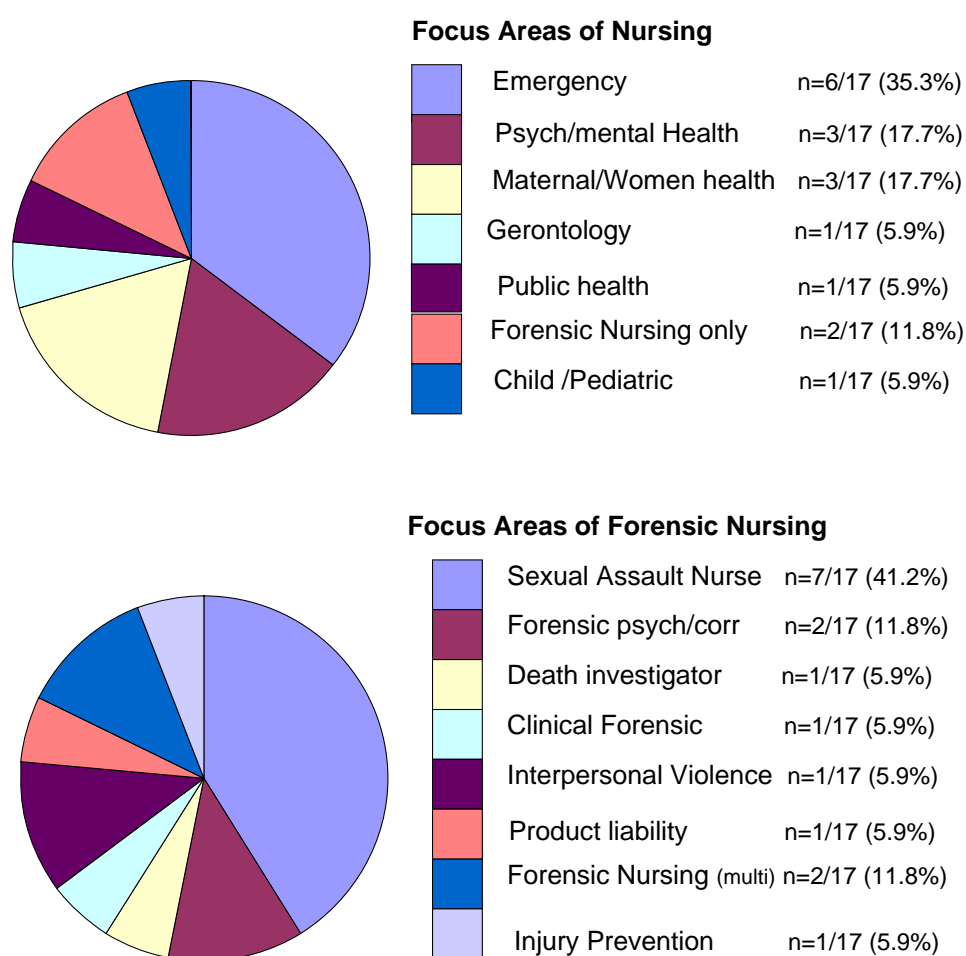
- I was an emergency room nurse before forensic nursing (Q6-P07)
- I have not practiced formally as a forensic nurse, but I believe I have practiced informally since day one of being a nurse. (Q6-P05)

Example data extracts from the qualitative interview with regard to direct clinical forensic nursing practice were:

- I made the course a combination of my clinical experiences running hospital based family violence intervention programs and sexual assault programs, but I also based the content on nursing literature. (Q2-P16)
- My personal clinical forensic experience is the main one. (Q6-P17)
- Not just clinical experience, but also experience testifying. But what really stimulated it. Was on, on the stand having to explain, in court what it was that I was doing. (Q6-P19)

#### ***S4. Main Focus Area of Nursing and Forensic Nursing***

The participants were asked what their main background or focus area of nursing was prior to focusing on forensic nursing, and then what their specific focus area of forensic nursing now is (See Figure 4.S4).



*Figure 4.S4.*

Main Focus Area of Nursing and Forensic Nursing

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Slightly more than one third (35.3%) of the participants stated that emergency nursing was their main focus area of nursing prior to focusing on forensic nursing; the remaining approximate two thirds represented six various other areas of nursing. One datum extract from the qualitative interview stated:

- I was an emergency room nurse and then I was a critical care nurse. And then I became a maternal/child nurse, then as a Clinical Nurse Specialist and that's where I had the majority of my experience. (Q6-P07)

Of the participants interviewed, 41.2% of the educators stated that their main focus of forensic nursing was sexual assault nurse examiners, followed again by seven other various subspecialties of forensic nursing. Examples of comparison data extracts from the qualitative interview with regard to the forensic nursing focus were:

- Working with women who were pregnant, women detoxing off of drugs, and going to jail. (Q6-P10)
- Running hospital based family violence intervention programs and sexual assault programs, but I also based the content on nursing literature. (Q2-P16)

#### ***S5. Forensic and Forensic Nursing Courses Taken for Credit***

When the participants were asked if they had taken any forensic related courses themselves for credit, 82.4% indicated they had. The types of courses included were: law, crime scene investigation, death investigation, victimology, sexual assault, criminology, forensic science, and public health with a forensic focus. Of the sample interviewed, 70.6% they had taken forensic nursing courses for credit. (See Figure 4.S5).

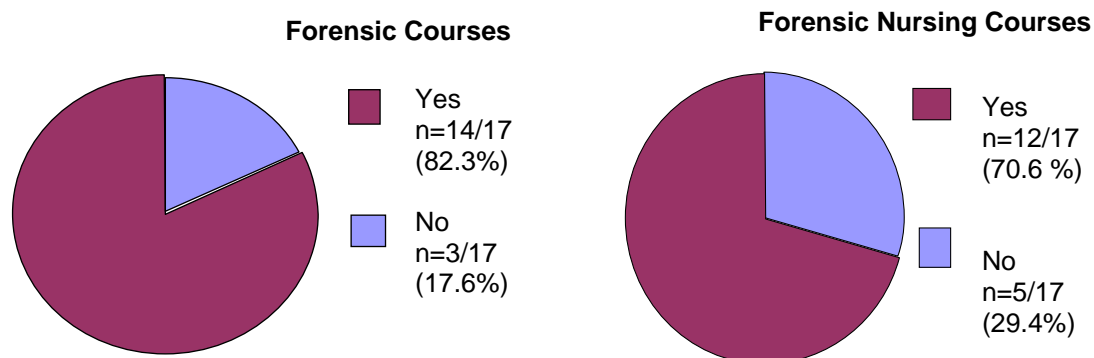


Figure 4.S5.

Forensic and Forensic Nursing Courses for Credit

Examples of comparison data extracts from the qualitative interview with regard to forensic courses and forensic nursing courses were:

- I had taken some criminology and forensic science courses before I started to teach. My Ph.D. in nursing and my law degree was done simultaneously. (Q6-P07)
- I took advanced courses within the Academy of Forensic Sciences. I took a fair amount of basic criminal justice courses and photography. (Q6-P11)
- Then I formalized that through a certificate in forensic nursing. (Q6-P02)

#### ***S6. Number of Forensic Courses Developed***

With respect to the number of forensic courses the 17 participants had personally developed, the range was 1 to over 30 courses. The one participant who had developed over 30 courses had written all SANE courses, where as the others developed a variety of forensic nursing subspecialty areas. (See Figure 4.S6).

Forensic Courses Developed		
<i>Range/Number</i>	<i>Forensic Courses Developed</i>	<i>Type of Forensic Courses</i>
1-7	n = 16/17 (94.1%)	Multiple areas of Forensic SANE courses
30	n = 1/17 (5.9%)	
Range	1 to over 30 courses	
Mean	5.95 courses	
Total Number	88 + courses forensic nursing courses developed by the participants	

Figure 4.S6

#### Number of Forensic Courses Developed

In total, the participants of this sample has developed over 88 forensic nursing courses. The full list of all the courses developed by the participants can be found in the Appendix. (See Appendix D2--Title of Courses Educators Developed--S6).

#### ***S7. Current Position and Status (Full time, Part time or Sessional/Contract)***

Educators were asked what their current position and responsibilities were and if their position was full time, part time, or sessional/contract. (See Figure 4.S7).

Most of the participants (82.4%) stated that their current position now was a full time faculty member, and many were directors of their forensic programs. Examples of data extracts from the qualitative interview with regard to current positions were:

- My full time job is the forensic SANE coordinator provincially. (Q11-P12)
- We're not a big department, I am really the only full time person devoted to Forensic. (Q13-P06)

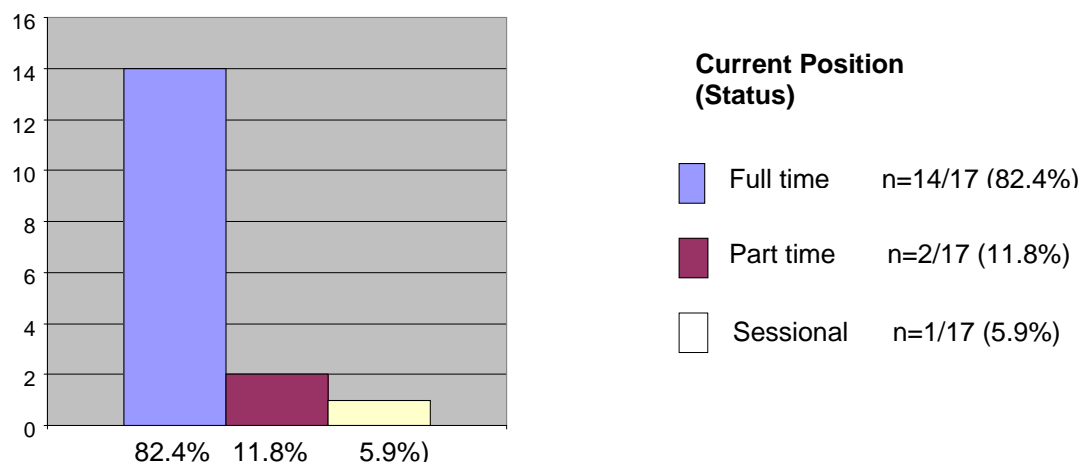


Figure 4.S7.

Current Position (Status)

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During the analysis, I came to the realization that perhaps many of the participants were not on faculty when they began to develop some of the early courses. Although I had not originally asked this question, I followed up by finding the answer to this by email. The results of this finding became significant to this study as one to two thirds of the participants were not in full time faculty nurses educator positions when they wrote their first forensic nursing courses.

#### ***S8. Number of Years of Experience Teaching Nursing and Teaching Forensic Nursing***

The 17 participants were asked to approximate the number of years of experience teaching nursing and the number of years they had in teaching forensic nursing. (See Figure 4.S8)

### Teaching Experience in Years

<i>Years of Experience</i>	<i>Teaching Nursing</i>	<i>Teaching Forensic Nursing</i>
0-9 years	n = 5/17 (29.4%)	n = 12/17 (70.6%)
10 yrs and over	n = 12/17 (70.6%)	n = 5/17 (29.4%)
Range:	0-42 years	3-29 years
Mean:	15.59 years	10.06 years

*Figure 4.S8*

#### Years of Experience Teaching Nursing and Forensic Nursing

Email survey in Phase I

Overall, the range of years of experience teaching general nursing by the 17 participants was 0-42 years with a mean of 15.59 years. In comparison, the range of years of experience teaching forensic nursing by the 17 participants was 3-29 years, with a mean of 10.06 years. Of note, the educators that had very little experience teaching did have many years experience in clinical practice, and those that had very little experience in clinical practice often had many years of teaching experience.

#### Phase 1b Analysis of Email Survey--Course Statistics (S11-S24)

In Phase 1b of this study, descriptive data were collected about the courses or programs the participants or educators developed. Again, where applicable, data extracts were inserted from the qualitative interview that supported the data from the course statistic demographics.

#### ***S9. Type of Educational Institution Where Forensic Course/Program Offered***

Information about the type of educational institution from which the forensic courses were offered was collected from the 17 participants. For this question the participants indicated that there were 23 different courses or programs of which the 17 participants had developed, because some developed more than one course. However, the

number of total courses developed by all participants ranged from 17 to 26 in subsequent questions, due to the fact that some were counting courses and some were counting programs (See Figure 4.S9).

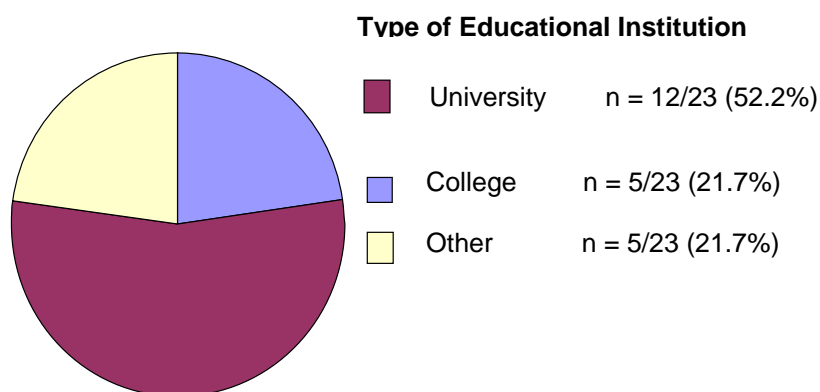


Figure 4.S9.

Type of Educational Institution

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When the participants were asked about the type of *educational institution* from which the course/ program was offered, the breakdown was: 52.2% offered at a university, 21.7% offered at a college, and 21.7% offered at other institutions, which included hospital or community. In addition, a response was that courses were also offered internationally.

#### ***S10. Needs Assessment Prior to Course Development***

When asked if a needs assessment had been done prior to course development, most (70.6%) stated that a needs assessment had been done. (See Figure 4.S10)



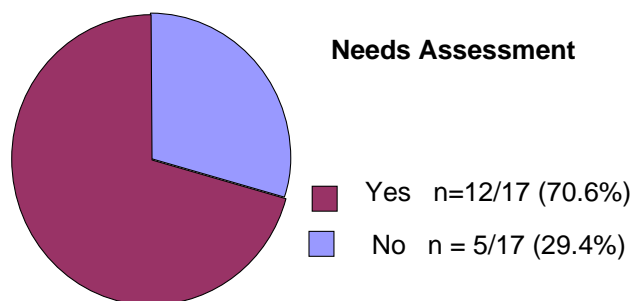


Figure 4.S10

#### Needs Assessment

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Random statements from the qualitative phone interview with relevance to if a needs analysis or needs assessment was done were:

- We did a survey and a needs assessment to try to come up with what was needed in developing a course. (Q10-P03)
- A needs assessment was done regarding forensic nursing. (Q10-P03)

#### ***S11. Educational Level of Forensic Course/Program***

The 17 participants indicated that the *level of courses* developed ranged from undergraduate courses and certificate levels to doctoral track programs. In response to this question 26 programs or courses were indicated because some participants had developed more than one level of program. (See Figure 4.11)

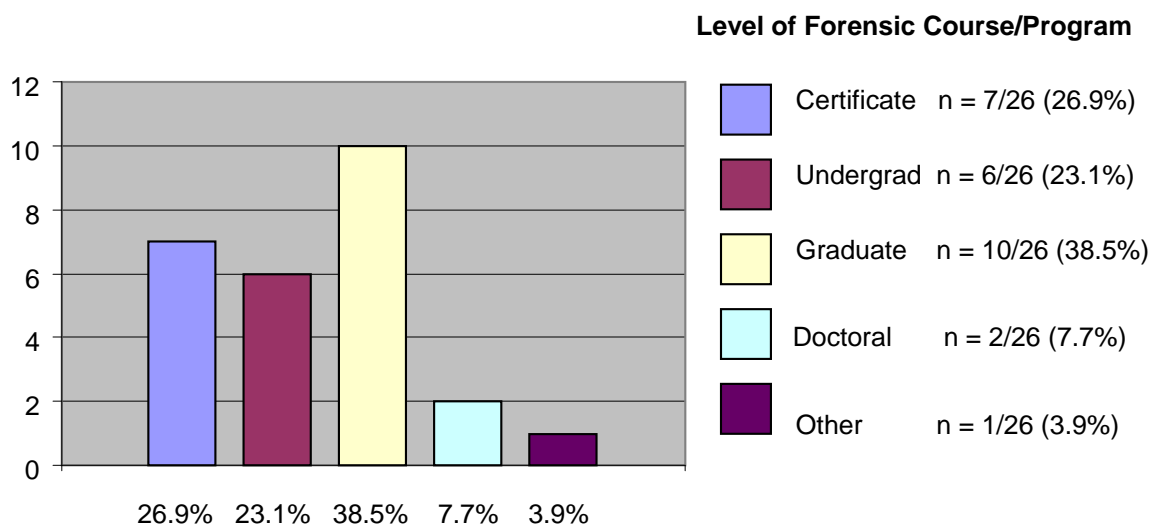


Figure 4.S11.

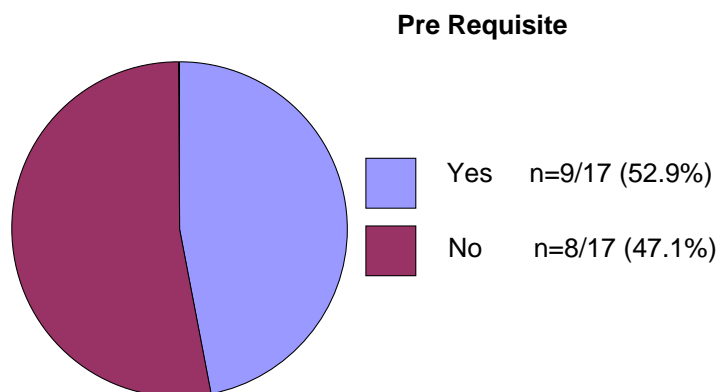
*Educational Level of Course/Program*

The graduate level was the most prominent educational level of courses/programs. The breakdown was: doctoral level (7.7%), graduate level (38.5%), certificate level (26.9%), undergraduate (23.1%), and, other (hospital/ non credit) (3.8%). As expected, the educational level of the educators correlated with the level of the courses they created. Comparable data extracts from the qualitative interview with regard to educational levels of courses were:

- We have a slowly growing number of universities and colleges who are beginning to create forensic nursing programs especially, advanced practice or master's level. (Q10-P16)
- Initially by having, the CEU programs based there, and then developing courses, and hopefully now developing whole tracts. (Q10-P20)
- Graduate degree programs either has forensic nursing as a part of their adult nurse practitioner program, or has a forensic nursing tract as one stream of their nursing graduate degree program. Also there are many educational institutions now who offer just a graduate forensic nursing degree program. I believe actually the tract in some ways probably makes more sense because it gives the graduate more job options. (Q10-P20)

### ***S12. Pre-requisite Required***

The participants or educators were asked if a pre-requisite was required in order to take the forensic nursing courses or program. (See Figure 4.S12).



*Figure 4.S12.*

Pre-requisite

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Slightly more than half of the participants (52.9%) responded that yes there was a prerequisite to the programs they developed. However, it was noted that the pre-requisite was usually that the student already be a health care professional accepted into a post diploma or post graduate program, rather than a specific prerequisite course.

### ***S13. Discipline of Students***

When participants were asked to which student discipline the courses were offered, the results were nursing only (58.8%) and nursing and other disciplines (41.2%). (See Figure 4. S13).

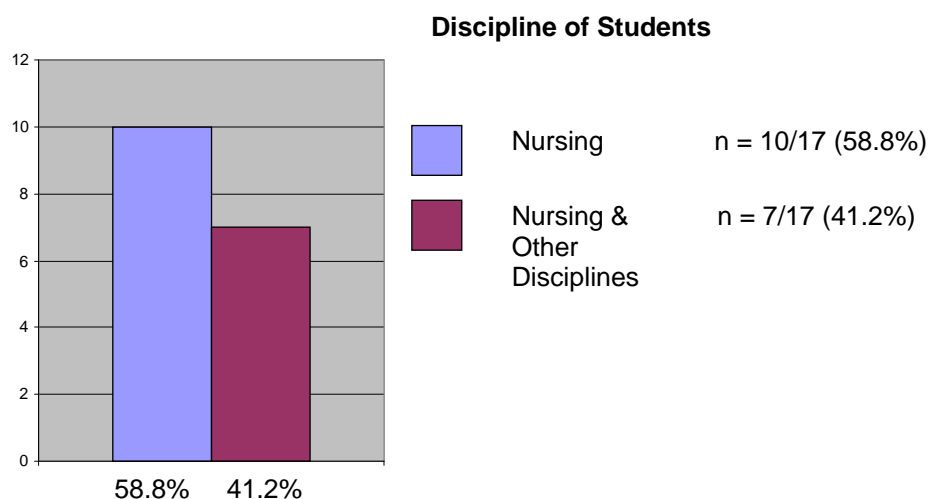


Figure4. S13.

#### Discipline of Students

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The qualitative data had several random references throughout to multidisciplinary education, one extract is cited here:

*Discipline of the Student*

- That multidisciplinary understanding. So it's predominantly aimed at nurses but, we do allow other professions to take the courses. (Q2-P02)

#### ***S14. Mode of Delivery***

(See Figure 4.S14 As indicated, some participants had developed more than one course or program and offered them at different levels and different modes of delivery. Mode of Delivery).

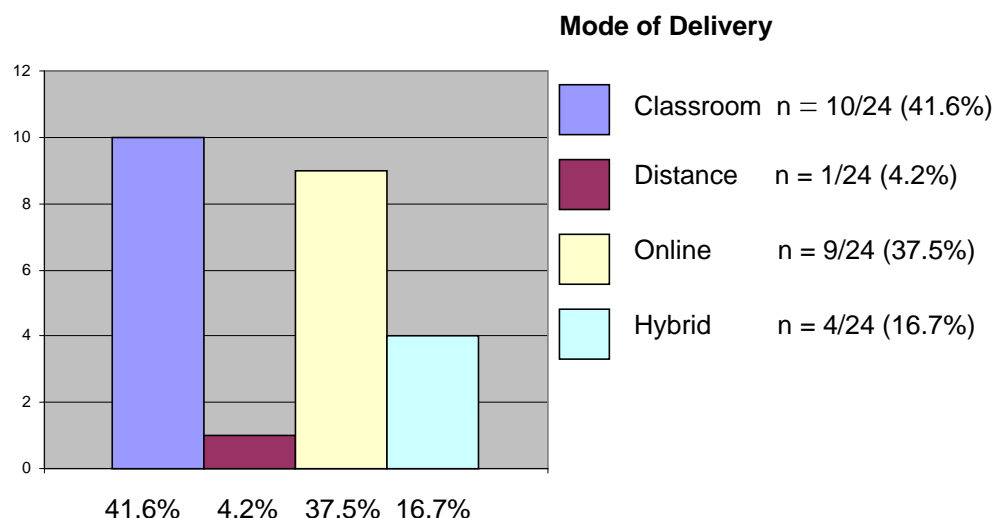


Figure 4.S14

Mode of Delivery

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*The mode of delivery* of the forensic nursing courses were divided between classroom (41.6%), web based (37.5%), and hybrid (16.7%) which was classroom and web enhanced, and distance (paper based) (4.29%). However, the clinical practicum component of sexual assault nurse examiner programs may have been a reason why online percentages were not higher. Comparable data extracts from the qualitative interview were:

- At the one University, it was a certificate program; that was an online course. At another University, it was a classroom course (Q3-P11).

### ***S15. Clinical Component***

In response to the question of whether there was a *clinical component* to their forensic nursing course/program offered, 76.5% of the participants said that there was. (See Figure 4.S15).

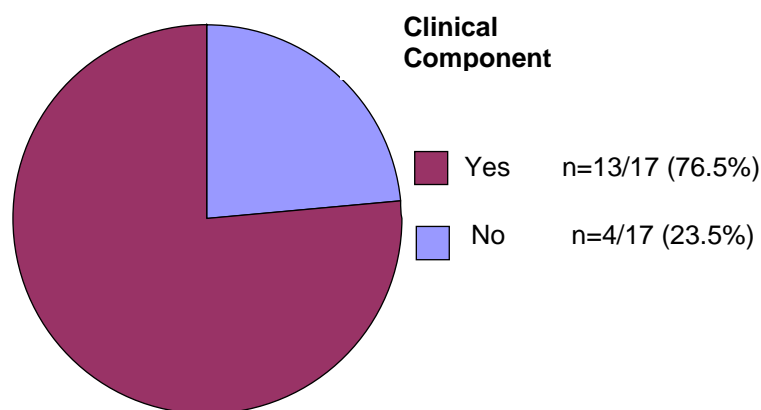


Figure 4. S15.

Clinical Component

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The sexual assault nurse examiner (SANE) courses comprised the majority of the statistics for courses with a clinical component. Of note, most courses at a masters and doctorate level were theory based. Comparable data extracts from the qualitative interview were:

*Clinical Component*

- For all SANE courses the clinical practicum is required because you cannot just take the course and sit in a classroom; clinical proficiency has to be demonstrated. (Q6-P12)

***S16. Year Forensic Nursing Course/Program First Offered***

The participants were asked what *year* their forensic nursing course/program was *first offered* at their university/college. In most cases these very first courses were developed by 76.5% of the participants of this study. (See Fig 4. S16).

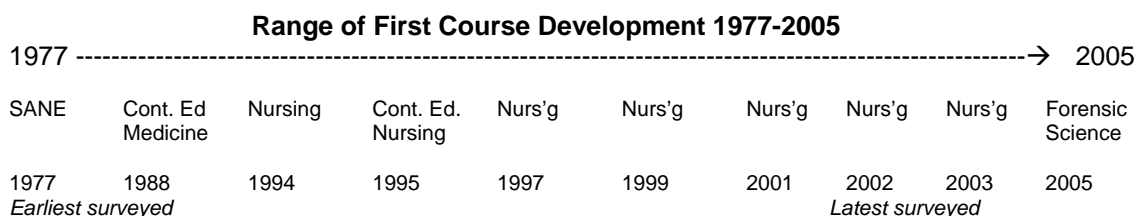


Figure 4.S16

#### Year Forensic Courses Started

The inaugural years of the forensic nursing programs in this survey sample ranged from 1977 to 2005. (See Appendix D3 Year Forensic Nursing Course First Offered). The 1977 date was a SANE course which represented historically the earliest SANE courses started in 1976, 1977 and 1978 in the US. Most of the participants were known to have developed some of the very first forensic nursing courses, as evidenced by the following data extract:

- The year that I did my first SANE training program would have been 1977. (Q6-P20)

In 1988, a general forensic nursing course was offered for the first time through the department of medicine in a continuing educational program in the US. Continuing education departments often provided a foot in the door or an initial home for specialty forensic nursing education.

- I had probably the first university approved continuing education forensic program; and that would have been in 1988. (Q8-P19)
- The courses first started in 1992. (Q12-P08)
- Probably the very first one at that University was in 1994, because we started working on it in '93, but 1994 was actually the first time we offered the course. (Q3-P11, Q4-P11)

***S17. Type of Forensic Course/Programs Offered (Description and Title)***

Participants were asked in Survey Question 17 the *number, name and title* of the forensic courses offered at their institution. This question was different from question S6 of the email survey because that question asked specifically the names of the forensic nursing courses they had personally written compared to the program of forensic nursing courses offered at their University. (See Appendix D4 for Title of the Forensic Nursing Courses at your University S17). The purpose of this question was to determine the following information for this study:

- Do programs have a Forensic Science focus or a Forensic Behavioural Science focus or both?
- Is an Introductory/Foundation Course common? (See Figure 4. S9)

**Forensic Course/Programs Offered**

<i>Types of Courses</i>	<i>Frequency</i>
• Included Nursing in the Title	n = 11/17 (64.7%)
• Introductory Course	n = 8/17 (47.1%)
• Both Forensic Science/Forensic Behavioral Sciences	n = 7/17 (41.2%)
• Only SANE Courses	n = 2/17 (11.76%)
• Only Forensic Science Courses	n = 1/17 (5.88%)
• Only Forensic Behavioral Sciences Courses	n = 1/17 (5.88%)

*Figure 4.S17.*

**Type of Forensic Course/ Programs Offered**

At first glance, it seemed there were too many variables to make any statistical analysis. However, the following distinctions or observations were noted to be evident in the descriptive data: 47.1% offered an introductory course. Many of the participants felt it was important to have an introductory or overview course that introduced all the areas of forensic nursing. At 41.2% of the institutions, both a forensic science and forensic



behavioral science component were clearly offered; in other words an offender and a victim focus. However, it was difficult to determine if this combination was present most of the time. Two of the educational centers only offered SANE Courses, and two educational institutions each either only offered a forensic science option or a behavioural science option. The term *Nursing* was noted to be included in the title of 64.7% of the courses/programs. Comparable data extracts from the qualitative interview noted that the term *Nursing* was not in the titles when participants were articulating the names of their programs:

- The *Advanced Specialty Certificate in Forensic Health Care*, is housed in the forensic science department. It's a program of its own. (Q3-P09)
- The program is called *Forensic Studies*. (Q6-P02)

Further analysis using this data was done in Question 7 of the telephone interview with regard to "Nursing in Title and Concepts to Include?" Participants were asked specifically if they had the term *nursing* in their program or course titles.

#### ***S18. Elective Options Available in Nursing Program***

The participants were asked what the number of *elective options* that were available in their general *nursing* program of study. The total number of course/programs was 19 because some referred to more than one level of program. (See Figure 4. S18a)

***Nursing Program Electives***

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Two Electives	n = 3/19 (15.8%)
One Electives	n = 7/19 (36.8%)
Zero Electives	n = 3/19 (15.8%)
Unsure if had any Electives	n = 4/19 (21.1%)
N/A (SANE Program)	n = 2/19 (10.5%)

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*Figure 4. S18a*

**Nursing Program Electives**

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The breakdown was: two electives (15.8%); one elective (36.8%); zero electives (15.8%); unsure if they had any electives (21.1%); and finally some (10.5%) felt that the question did not apply as their courses were SANE courses only. However, one respondent did have a comment about the need for the SANE course to be a recognized elective in colleges and universities (See S21. Other Comments). Comparable data extracts from the qualitative interview with regard to elective options were:

- No elective options in that we have not had any specialized elective courses that the students could even access. (Q9-P01, Q10-P01)

***Forensic Nursing Courses/Program Required or Elective Options***

When participants were asked if their forensic course/programs were *required* or *elective* in their curriculum, some referred to more than one level of program. Of the 19 courses or programs, 18.4% were required, compared to 36.8% that were elective. In addition, 15.8% stated this question was not applicable because their course/program was a SANE course. (See Figure 4. S18b)

***Forensic Elective or Required***

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Required	n = 9/19 (47.4%)
Elective	n = 7/19 (36.8%)
Non Credit (SANE Program)	n = 3/19 (15.8%)

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*Figure 4. S18b*

**Forensic Nursing Courses/Elective or Required**

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When asked if the forensic courses were required or elective, many (47.6%) were required probably due to the fact that they were entire graduate programs. Comparable data extracts from the qualitative interview were:

*Required or Elective*

- It's a mandatory course for my master's students. For example this semester I have five new students and it's a mandatory introductory course, yet I have sixty- six nursing students enrolled in it because it's an elective for the undergraduate and other graduate programs. (Q8-P16)
- At the University, it was an elective. (Q3-P11)

***S19. Number of Semesters a Year Forensic Nursing Courses Offered***

The number of semesters the forensic nursing courses were offered per year were calculated as: one semester a year (36.8%); two semesters a year (31.6%); three semesters a year (5.3%); and, inapplicable (26.3%) was stated by some participants as SANE courses were not offered by semester. (See Figure 4. S19)

### Number of Semesters a Year Offered

#### *Semesters*

---

1 Semester	n = 7/19 (36.8%)
2 Semesters	n = 6/19 (31.6%)
3 Semesters	n = 1/19 (5.3%)
N/A as (SANE Program)	n = 5/19 (26.3%)

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Figure 4. S19

Number of Semesters a Year Forensic Courses Offered

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### ***S20. Average Number of Students Registered in Forensic Courses/Programs***

The number of students registered in the forensic nursing course(s) offered by the participants in 2006, ranged from five students to well over 100 a semester. One extract in the data from the qualitative interview revealed:

- The numbers game having 250 people in every class is very hard. When it comes to evaluating them and marking their paper assignments. (Q8-P15)

### ***S21. Other Comments***

When asked if there were any further comments to add about the email survey questions, n = 5/17 (29.4%) of the participants had a further comment. A theme common to the email survey and the phone interview was the point that often there is not room in the curriculum for specialty courses.

#### *No Room in Curriculum for Electives*

- Due to the nature of our current curriculum at the undergraduate level, there really is no place for an elective course in nursing; the curriculum is full with what is deemed essential nursing content. These specialty areas are still selected by students for senior clinical practica, but they do not have a formal course of study to support their clinical. Also, there is no requirement for certification in forensic nursing, so apart from personal and professional interest, there are no other reasons for a nurse to take this course. (S24-P01)

*SANE Program Needs University credit Recognition*

- The SANE program is not recognized at the university/college level. We expect that will happen in the next year. It is organized and run by clinicians with expertise in their field. I participated in the development of the program. I also run it 2x per year for the nurses who work within our Sexual Assault Centres. (S24-P12)

Comparable data extracts from the qualitative interview were:

- Often curriculums are full, no room for electives. (Q10-P01)
- Forensic concepts are integrated throughout all nursing content. (Q7-P07)

The other concern expressed in other comments in the survey was with regard to the need for the SANE courses to be offered at the university level. Comparable data extracts from the qualitative interview were:

- The key was when nursing educators recognized that this specialty was one that was needed, but they didn't have an infrastructure to address it. (Q11-P19)
- Most of the SANE programs in the US or Canada are not actually college accredited? We sort of gained some provincial recognition just by virtue of volume of nurses being trained, and promoting it in a certain way, but there is no credit from any higher institution, and there really should be. (Q11-P12)

*Summary Analysis on Phase I, Descriptive Statistics*

Along with the process of doing a predominantly qualitative study, descriptive statistics were collected to elicit some demographic data about the nurse educators as participants, and to gather some basic information about the forensic nursing courses they developed. The demographic statistics about the participant's education and clinical experience provided background information about where the participants gained their knowledge to write the courses and subsequently about their conceptualizations of forensic nursing that was addressed in Phase II.

*Phase Ia--Nurse Educator--Demographic Summary*

*Location and gender.* The participants of this study represented nurse educators from the US, n=13/17 (76.5%); and, from Canada, n=4/17 (23.5%). The gender breakdown was: female, n=16/17 (94.1%); and male, n=1/17 (5.9%). The ratio of women to men in this study reflected the overall ratio of men to women in the nursing profession, which is approximately 5% in Canada and in the United States (ANA, 2003; CNA, 2002a).

*Highest level of education achieved.* Findings from the descriptive statistics showed that the participant's highest level of education preparation ranged from baccalaureate to doctorate. Of note all the doctoral prepared educators, n=11/17 (64.7%) were from the US. Of the doctoral candidate educators: two of the three were from Canada, n=03/17 (17.6%); there were two mastered prepared educators, n=2/17 (11.8%), one from each country; and, finally one baccalaureate prepared educator, n= 1/17 (5.9%) from Canada.

*Clinical experience, teaching experience, and focus.* The educator's clinical experience in nursing ranged from 1-35 yrs and 0-29 in forensic nursing practice. The participant's teaching experience ranged from 0-42 years and their experience teaching forensic nursing ranged from 3-29 years. Almost one third of the participants stated that emergency nursing was their main focus area of nursing prior to focusing on forensic nursing, this was followed by six other various areas of nursing. Of the participants interviewed, almost half of the educators in this sample, n=7/17 (41.2%) stated that their

main focus of forensic nursing was sexual assault nurse examiners, followed again by a seven other various subspecialties of forensic nursing.

*Forensic courses taken and developed by the educators.* When educators were asked if they had taken any forensic related courses themselves for credit, many stated they had  $n=14/17(82.4\%)$  and many stated they had in fact taken forensic nursing courses  $n=12/17(70.6\%)$  for credit. The numbers of forensic nursing courses developed by the participants ranged from 1-30 forensic nursing courses each.

*Current position.* Most of the participants,  $n=14/17(82.4\%)$  stated that their current position was a full time faculty member, and many were directors of their forensic programs. Most significant however was a finding that was not originally asked but followed up on later. This finding was that  $n=7/17(41.2\%)$  of the participants were not on faculty when they wrote and taught their first course, in addition they were prepared at the masters level at the time, and one was at a baccalaureate level,  $n=1/17(5.9\%)$ . Although all doctoral prepared educators in this sample were from the United States, it was masters prepared educators from both countries that wrote the very first courses, both prior to being on full time faculty and without a PhD. This became a significant finding as it spoke to both the passion and the determination of many individual educators in multiple locations with a compelling mission to establish forensic nursing courses into the nursing curriculums. In addition, many of the initial courses were written and developed with little if any compensation.

For a chart summary of Phase I descriptive statistics see Appendix E (See Appendix E1--Summary of Educators Demographics, S1-8)

*Phase I(b) Course Statistics Summary*

Information about the forensic courses developed was collected from the participants. Literature comparisons were added where applicable.

*Type of institution where forensic courses offered.* Of the 23 forensic nursing programs/courses developed by the 17 educators, most courses were offered at: university,  $n=12/23$  (52.2%); followed by college,  $n=5/23$  (21.7%); and, other institutions like hospitals and international training courses,  $n=5/23$  (21.7%).

*Needs assessment.* A needs assessment was done in most of the cases,  $n=12/17$  (70.6%) prior to course development. The literature review in Chapter Two documented numerous studies of research over a span of the last 30 years where a needs analysis was done indicating a need for forensic nursing education. However, educational courses did not quickly develop.

*Educational level of courses.* Forensic nursing courses were most frequently offered at the graduate level. Hanson and Hamric (2003) indicated that in the third stage of specialty development there was pressure to move certificate-level training programs into formal graduate-level educational settings, both as a means to increase standardization and to raise the standards of the specialty to an advanced practice level.

In this study, the graduate level was the most prominent educational level of courses or programs. The breakdown was: doctoral level,  $n=2/26$  (12.5%); graduate level,  $n=10/26$  (38.5%); certificate level,  $n=7/26$  (26.9%); undergraduate,  $n=6/26$  (23.2%); and other (hospital/ non credit);  $n=1/26$  (3.8%). Not surprisingly, the educational level of the



educators correlated with the level of the courses they created. For the most part graduate and doctoral level courses were only developed by educators at that academic level.

*Pre-requisite.* About half of the forensic nursing courses offered, required a pre-requisite, n=9/17 (52.9%). That pre-requisite was that the student was already admitted to a health or service related program of study (e.g., nursing, psychology, social work, police, or law) at the undergraduate or post graduate level.

*Open to other disciplines.* When asked to which student discipline the courses were offered, the results were nursing only, n=10/17 (58.8%) and nursing and other disciplines, n=7/17 (41.18%). The literature review indicated that a number of studies have been done on the benefits of multidisciplinary training in the forensic area. The following is a marketing advertisement that targets many disciplines for forensic courses offered by nursing:

*Forensic health studies courses open to all disciplines.* This College is launching this province's first program in forensic health studies to meet an increasing demand from nurses. Paramedics, paralegals, children's aid social workers, and law enforcement professionals will also benefit from the postgraduate certificate program, beginning in October. (Naiman, 2006)

*Mode of delivery.* The mode of delivery of the forensic nursing courses were almost equally divided between: classroom, n=10/24 (41.7%); web based, n=9/24 (37.5%); hybrid, n=4/24 (16.7%) which was classroom and web enhanced; and in addition to distance (paper based), n=1/24 (4.2%). Since 1995, when the first web-based course was delivered in California (Bates & Poole, 2003), there has been a move toward web-based learning modalities for nursing education. In an increasing technology-

sophisticated world, it is important for nurse educators to take full advantage of this technology to enhance learning.

A study was done in 1998 in Canada on the technology of online delivery of a forensic nursing program (Harvey, 1998). This early forensic nursing educational study found that the reasons for taking the forensic nursing course online were the new mode of delivery and interest in the forensic content area. Accessibility, convenience, and flexibility were also mentioned as reason for taking this early online course (Harvey, 1998).

*Clinical component.* It was determined that most of the programs had a clinical component (n=13/17). This finding mostly represented the SANE courses.

*Year forensic nursing courses first offered.* Each participant was asked what year their forensic nursing course was first offered at their college or university. The inaugural years of the programs surveyed ranged from 1977-2005. The 1977 date was a SANE course which represented historically the earliest SANE courses started in 1976, 1977 and 1978 in the US. In 1988, a general forensic nursing course was offered for the first time through the department of medicine in a continuing educational program in the US. Continuing education departments often provided a foot in the door or an initial home for specialty forensic nursing education. Once the success and popularity of the courses were public, the programs were in demand by the main nursing departments.

In the early to mid nineties, two or three introductory general nursing courses and programs came on the scene that were sustained and developed into complete programs: Beth El College, Colorado in the west, Fitchburg State College, Massachusetts in the east

and University of Calgary and Mount Royal College in Alberta, Canada. Not all the forensic nursing course/program were sustained, and this fact was addressed in the telephone interview in Phase II when participants were asked about factors that facilitated and impeded the sustainability of programs.

In 1976, the first SANE program was established in Memphis, Tennessee. In September 1977, the Sexual Assault Resource Service began in Minneapolis, Minnesota (Ledray, 1992). In 1978, the sexual assault nurse clinician program began in Amarillo, Texas (Ledray & Arndt, 1994). The earliest university college course cited in the literature was offered in 1983 at the Catholic University of America in Washington, however it was only offered for one year, due to lack of funding (Bernier, 1986).

*Titles and types of courses.* When the types of forensic nursing courses developed were tabulated, it was determined that many programs had an introductory course (n= 8/17). Many of the educator/participants (47.1%) felt it was important to have an introductory or overview course that introduced all areas of the forensic nursing. Many of the participants stated their programs represented only forensic science, n= 7/17 (41.2%); two of the participants stated their programs had both a forensic science /forensic behavioral science component, n= 2/17 (11.8%); and, one participant stated her course represented only forensic behavioral science, n= 1/17 (5.9%).

*Elective or required.* When asked if the forensic courses were required or elective: most stated they were required, n=9/19 (47.4%), probably due to the fact that they were graduate programs. The elective option courses were recorded as n=7/19

(36.9%), and some ticked off not applicable,  $n=3/19$  (15.8%) because the course was a SANE course.

*Elective options in general nursing program.* It was asked if the participant's general nursing program had any elective options: the findings were two electives,  $n=3/19$  (15.8%); one elective,  $n=7/19$  (36.8%), had zero electives,  $n=3/19$  (15.8%), unsure,  $n=4/19$  (21.1%) and some did not apply as they were SANE courses,  $n=2/19$  (10.5%) offered in the hospital or community.

*Number of semesters a year offered.* The number of semesters a year the forensic nursing's course were offered was calculated as 1 semester a year,  $n=7/19$  (36.8%), two semesters a year,  $n=6/19$  (66.7%), three semesters a year,  $n=1/19$  (5.3%), and  $n/a$ ,  $n=5/19$  (26.3%) as they were SANE courses.

The IAFN Education Committee explored how to develop forensic health care information for use in undergraduate nursing programs. Typically, undergraduate programs of study were packed with required content that supported the students as they prepared for nursing board examinations. "Programs allow little flexibility for adding new content, despite the fact that the content is in high demand" (Crane, 2005, p. 4).

*Number of students registered.* The average number of students a year registered in the forensic course/program ranged from 5-100+ students a semester.

*Other comments.* At the end of the survey the final question asked if the participants had other comments. The educators expressed that often the curriculums were too full their for not room for electives or specialty courses and that there was a need for the SANE courses to be offered at the university level. The issue of packed

curriculum was addressed in the literature as well. The curriculum often is packed with no flexibility for student's to take specialty courses of interest (Crane, 2005). In addition, there was the need for the SANE courses to be recognized for credit at a college or university level.

A brief summary of the course statistics in a table provides a review of the analysis at a glance (See Appendix E2. Phase Ib--Summary of Course Statistics, S9-S21)

- ❖ This bullet signifies a newly constructed finding, definition, or theme that resulted from this study.

#### Phase II: Data Analysis – Qualitative (Telephone) Interview

In the last part of Chapter Four, I present Phase II or the analysis of the qualitative data from the telephone interview (Questions Q1-13). Phase II involved interviewing the participants by telephone using a list of semi-structured questions

I produced a table using the template designed in Steps One to Four of the thematic analysis as shown in Chapter Three. As mentioned previously, although 17 participants completed the email survey, only 16 participated in the phone interview, therefore  $n=16$  was my sample for Phase II. The following is the analysis to the responses of the research questions (Q1-13) I asked each Educator. With some questions I prompted respondents to elaborate or I asked additional questions, depending on the response. For each question, I inserted examples of data extracts. For some questions, the descriptive statistics were compared to the qualitative responses. Finally, I began to construct some interpretations or understandings to the results of the analysis from a constructivist perspective, that I termed *constructed connotation*, meaning constructivist implications. Also with each

question, I made the decision as to which points constituted relevance to be the main *Knowledge themes* and *Factors Influencing themes* of the study.

### ***Q1. Forensic Nursing***

Question 1 asked participants “What is forensic nursing?” This was the first question the forensic nurse educators were asked in the phone interview and it proved to be *key* because the framework or template initiated for this question was applied with little modification for the first five questions. The participants responded by either defining forensic nursing or describing elements about it. I sorted the responses into the following categories:

- Forensic nursing IS...
- Forensic nursing IS NOT...
- Forensic nursing IS DIFFERENT FROM...
- Forensic nursing IS A COMBINATION OF...
- Forensic nursing WAS or USED TO BE...
- Forensic nursing WORDS that should be included in a definition ARE...
- Forensic nursing MISSING in most DEFINITIONS IS...
- Forensic IS...
- Nursing IS...
- Medicine IS...

In addition to the division of the data into categories, the other divisions or columns were descriptors (which became typologies) and the early or initial knowledge themes of the study. (See Table 4.1. Question 1)

Table 4.1.

*Q1. What Forensic Nursing Is*

<i>Categories</i>	<i>Early Themes</i>	<i>Descriptors-Typologies</i>
Is:	Knowledge DELINEATION theme	• Forensic Prefix
	Knowledge DESCRIBED theme	• Forensics (noun)
	(Descriptors Typologies)	• Unique as Prefix
Is:	Knowledge DEFINITION theme	• Law/ Legal Prefix
	(Constructivism – It depends,	• Legal Relationship
	both/and, not only/but also)	• Forensic Population
Is not:	Antithesis	• Forensic Specialties
Is influenced by:	Knowledge DEVELOPMENT theme	• Forensic Systems
	(Constructivism – It depends)	• Forensic Services
Is a combination of:	Knowledge DUAL ROLES theme	• Forensic Care
	(Constructivism – both/and)	• (Forensic)
Was:	Knowledge HISTORY theme	Nursing Process
Nursing is:	Knowledge DEMARCATION theme	• (Forensic)
Medicine is:	Knowledge DEMARCATION theme	Nursing Paradigm

*Forensic Nursing Is*

When articulating what forensic nursing is, the 16 educators defined or described forensic nursing from their perspective using the terms: Is...., Is not...., Is a combination of..., Used to be... Examples of data extracts were:

- Forensic nursing is any area of practice where the profession of nursing intersects with the law. (Q1-P07)
- Forensic nursing is simply the care of special population that happens to be involved with either the criminal justice system or involved with basic issues of either violence or crime. (Q1-P10)
- Forensic nursing is a way to improve services for victims, ensure that their needs are met, and a way to reduce crime by holding criminals or assailants accountable. (Q1-P20)
- Forensic nursing is in the context of injury to a person, a family, a community or the world. (Q2-P19)

*Forensic Nursing Is Not*

Some educators stated what forensic nursing was not, in their attempt to clearly

articulate what it was. Examples of data extracts were:

- Forensic nursing is not an addition, or an extra level of nursing care. (Q1-P03)
- Forensic nursing is not isolated to the areas that have been identified across the lifespan of a patient, from birth until death. (Q1-P09)
- Forensic nursing is not going to be constrained to only one discipline –this practice is a multidisciplinary practice model that requires liaisons with law enforcement/medicine/the criminal and civil systems as well as colleagues such as IAFN. (Q1-P03)

#### *Forensic Nursing Is Different (unique)*

In articulating what forensic nursing is, many educators stated how forensic nursing was *different* meaning *unique*. An example from the data extracts was:

- Forensic nursing is unique because it serves the population of victims of violence, and perpetrators in a way that they haven't been served before. (Q1-P17)

#### *Forensic Nursing Is a Combination Of*

Some educators stated forensic nursing was a combination of concepts. Examples of data extracts were:

- Forensic nursing is some combination of nursing with something legal. (Q1-P15)
- Forensic nursing is a combination of, the science part and (the art) or humanity part. (Q5-P11)

#### *Forensic Nursing Was or Used To Be*

Some educator/participants said it was a difficult question to answer because, what forensic nursing is, was a process and a concept that has evolved. Examples of data extracts were:



- Forensic nursing is more than the IAFN definition now. I used to use that definition but there is something missing in it now. (Q1-P11)
- Forensic nursing was an umbrella term to cover the all aspects of nursing, my conceptualization then was there's an umbrella instead of a function. (Q1-P19)

*Forensic Is, Nursing Is, Medicine Is:*

In answering this question, some of the participants also articulated their perspective of what forensic was, what nursing was, and what medicine was. Examples of data extracts were:

- Forensic to me means pertaining to law. (Q1-P15)
- Nursing is still the essence of forensic nursing. (Q1-P01)
- Nursing is health focused and comprehensive, unlike medicine which is disease focus. (Q1-P19)
- Nursing has always been the best provider, from a forensic point of view to the patient who has to intersect with the legal system. (Q1-P19)
- When nursing is the licensed profession, it's the health and legal that pull nursing into it. (Q1-P19)
- ....unlike medicine which is disease focus. (Q1-P19)

*Constructed Connotations*

In addition to the template of the categories, the first question "What is forensic nursing" also provided the start of many knowledge descriptors (typologies) and the main knowledge themes that maintained throughout the rest of the study, specifically the Definition Constructed Theme (See Chapter Five, Findings):

- ❖ Knowledge Concepts to Include
- ❖ Knowledge Differentiated
- ❖ Knowledge Dual
- ❖ Knowledge Defined (constructed definition)

### *Q2. Conceptualization of Forensic Nursing in Course/Program*

Question Two asked participants how their forensic nursing course/program was conceptualized? Conceptualization was defined as: arriving at a concept or a generalization as result of things being seen, experienced or believed (Thesaurus, 2007) (See Table 4.2. Question 2).

Table 4.2.

### *Q2. Conceptualization of Forensic Nursing in Educational Programs.*

<i>Categories</i>	<i>Subcategories</i>
Is, or should be (focus) ...	<ul style="list-style-type: none"> <li>• Nursing (n=8/16)</li> <li>• Broad (n=3/16)</li> <li>• General (n=3/16)</li> <li>• Legal system (n=1/16)</li> <li>• Multidisciplinary (n=2/16)</li> <li>• Forensic Science (n=1/16)</li> </ul>
Is not... or should not be... or should not be... (focus)	<ul style="list-style-type: none"> <li>• Not forensic piece</li> <li>• Not forensic science only</li> <li>• Not technical skills</li> <li>• Not the injury only</li> </ul>
Is a combination of...	<ul style="list-style-type: none"> <li>• Law and Forensic Science</li> <li>• Clinical Experience &amp; Literature</li> <li>• Nursing and Criminology</li> <li>• Nursing Art and Science/</li> <li>• Behavioral Sciences/Forensic Sciences</li> <li>• Victim/Perpetrator/Deceased</li> </ul>
Is influenced by...	<ul style="list-style-type: none"> <li>• Affiliations, partnerships</li> <li>• Educators personal experience</li> </ul>
Was... Concepts needed to be included are...	<ul style="list-style-type: none"> <li>• Umbrella term</li> <li>• Throughout data</li> <li>• See Taxonomy of Concepts to include in findings from Question 7</li> </ul>

I felt it would be valuable to have a collected perspective of how forensic nursing courses had been conceptualized by participants who represented educators who had developed and taught many of the first forensic nursing educational programs. The categories followed the template of the first question. The conceptualization of forensic nursing: Is...; Is not...; Is a combination of... Is influenced...

*Conceptualization of Forensic Nursing Is*

When the educators/participants were asked how they conceptualized forensic nursing content in their courses course/program of delivery, some participants described the areas of knowledge they focused on, and some stated clearly how it should be conceptualized and how it should not be conceptualized.

*Nursing first.* The consensus of the educators regarding how forensic nursing should be conceptualized was that half of the educators stated it should be conceptualized as *nursing* first and foremost. Examples of the data extracts were:

- To me the forensic nursing courses are really conceptualized as nursing, and that it's nursing first and that you're looking at the unique attributes and the unique problems that the client presents with. They might be slightly different in other areas of practice and looking at how the environment impacts on that client's health and well-being (Q2-P01).
- Obviously our major status is nursing. Our specialty in nursing is forensic. (Q2-P08)

*Broad, generally, multidisciplinary.* The other half of the educators felt it should be conceptualized broadly, or generally, and more from a multidisciplinary context, to show the broad scope of forensic nursing and therefore felt there should first be a foundational or introductory course. Examples of data extracts were:

- Conceptualizing this broad focus and enhancing and expanding the underpinnings of nursing practice. (Q2-P03)

- Our program is what I refer to as a forensic nursing generalist program. It incorporates content areas specific to the forensic sciences, forensic chemistry we also have a course on forensic toxicology, and a death investigation medical examiner's course. And a crime scene and evidence course that really fits more in, kind of that generalist track, that generalist domain of practice. (Q2-P06)
- Courses are best conceptualized as multidisciplinary, conceptualization, with forensic teams. We also need to know each other's roles. (Q2-P09)

*Nursing science/behavioral science and forensic science.* Other educators

said they conceptualized forensic nursing in three distinct areas because they had three courses for victim, perpetrator (behavioural sciences) and forensic sciences. Examples of data extracts were:

- How did I conceptualize it? Of the three I teach, one is focused towards victims, so it's a victim perspective, and the forensic mental health is about the behavioral aspect and forensic science is forensics or forensic science. (Q2-P15)
- That's certainly a very large component is what I would consider behavioral sciences, forensic psychology, psychiatry. Where we look at not only the physiological effects of trauma on victims, but also the psychological consequences, and certainly one course completely focuses on perpetrator behavior. (Q2-P06)

*Conceptualization of Forensic Nursing Is Not*

Some educators had strong feelings about how forensic nursing should not be conceptualized. They believed that the focus should not be on the technical skills, the evidence collection, the injury, the legal consequences, or the forensic science aspect of it; but rather the focus needed to be about the person that we are caring for and providing services to. They felt that the forensic piece should not be more prevalent than the nursing aspect. Examples of data extracts were:

- A specialty in nursing is forensic, NOT a nursing specialty in forensics. (Q2-P08)

- My emphasis is on the nurse, and the forensic is not so relevant. (Q2-P12)
- The forensic sciences were only a piece of that, because all by itself it couldn't stand. But it was there present much like public health was present. (Q2-P19)
- We're not looking just at the injury per se, or, or the legal consequences, but we're looking at the individuals. The individual as a whole to protect themselves. (Q2-P05)
- Forensic nursing is not all about evidence collection, they are just technical skills – forensic nursing needs to first be about the person sitting there in front of you any how the injury abuse, violence has impacted their lives and what the nurse can do to care for, intervene, prevent and protect them. (Q2-P12)

### *Conceptualization of Forensic Nursing Is Influenced By*

In addition, some educators stated that it had been conceptualized for them because of some affiliation or collaborative partnerships already in place. Examples of data extracts were:

- Because of our unique affiliation agreement with, and our unique circumstance in our city where we have an affiliation agreement with a federal psychiatric facility, in many ways the forensic parameters were already outlined for us. (Q2-P01)
- Focused on this goal, and that was to collaborate with the School of Law, so that our students would get a clear understanding of the law and from many different perspectives. (Q2-P17)

### *Conceptualization of Forensic Nursing Depends On*

Some educators admitted that how the courses were conceptualized depended on their own personal experience, because that is what they knew best. One educator said that she/he had conceptualized it themselves in that they had come up with their own framework or model of how forensic nursing was conceptualized to them. Examples of data extracts were:

- I made the course a combination of my clinical experiences, the literature and also talking with some of the colleagues who have created programs throughout the country prior to the one I created. (Q2-P16)

### *Conceptualization of Forensic Nursing is a Combination Of*

One educator conceptualized it by a combination of his/her clinical experience, nursing literature, and talking to other colleagues who had already developed forensic nursing courses. Others felt forensic nursing was a combination of nursing and forensic science and the law; clinical experience and the literature; and, nursing and criminology.

Examples of data extracts were:

- Forensic nursing is a broad combination of forensic science and being comfortable with the law. (Q2-P17)
- I made the course a combination of my clinical experiences running, hospital based programs, and also the literature and also talking with some of the colleagues who have created programs throughout the country prior to the one I created. (Q2-P16)
- It is nursing and it's a combination of nursing and criminology. (Q2-P20)
- The other things that I would use to conceptualize forensic nursing education, would probably be strong social context of legal systems and processes. (Q2-P10)

### *Constructed Connotations*

In responding to the question on conceptualization some educators said they wished they had given this question more thought prior to the telephone interview because it was difficult to articulate. Others stated specific core concepts that needed to be included or specific courses. The findings of Question 2, "How Conceptualized?" contributed to the main themes of the study (See Chapter Five, Findings):

- ❖ Knowledge Concepts to Include
- ❖ Factors Influencing

### ***Q3. Philosophical Base of Forensic Course/Program***

Question Three asked participants what the philosophical base was of their forensic nursing course or program. Knowledge of the philosophical base is important when exploring the knowledge of any specialty or discipline. The responses of the educators to the question of the philosophical base of the course or the programs were sorted into categories of the philosophical base of forensic nursing: Is not...Is a combination of ... Is influenced by... Is the same as... Some participants mentioned what the philosophy of the graduate program was (See Table 4.3. Question 3).

#### *Philosophy of Forensic Nursing Is*

When the 16 participant/educators were asked what the philosophical base of their forensic course or forensic program was, they responded by sharing their views as well as the profession of nursing's ideologies. Nursing as core and a multidisciplinary context were common views expressed.

*Nursing.* Nine replied that nursing was the core or the base or the primary philosophical area. Six stated that philosophy was caring, three stated holism, and three stated humanism. Others mentioned concepts like diversity, ethics, and prevention were important to include. Examples of data extracts were:

- That caring philosophy permeates not just the courses but the programs and indeed for me, what I think nursing is. And if they're not all the same, than I think that's where we get into trouble, in terms of education. (Q3&4-P10)
- Holism and caring are the philosophical foundations of the forensic program. (Q2-P03)

Table 4.3.

*Q3. Philosophical Base of Forensic Course/Program*

<i>Categories</i>	<i>Sub Categories</i>	<i>Descriptors</i>	<i>Theme</i>
PHILOSOPHY			
Is...	<ul style="list-style-type: none"> <li>• n=9/16 Nursing</li> <li>• n=6/16 Care/caring</li> <li>• n=4/16 Holism</li> <li>• n=3/16 Humanism</li> <li>• n=3/16 Multidisciplinary</li> <li>• n=3/16 Forensic Science</li> <li>• n=3/16 Knowledge</li> <li>• n=2/16 Patient Care</li> <li>• n=2/16 Person</li> <li>• n=1/16 Population health</li> </ul>	Nursing Process	Core concepts
Is not...	<ul style="list-style-type: none"> <li>• Not victim care, not survivor care- it is patient care</li> <li>• Not just technical skills</li> <li>• Not just forensic science</li> <li>• No philosophical base</li> <li>• Not a specialty so nursing philosophy</li> <li>• If caring paradigm not present we get into trouble</li> </ul>	Patient Care	
Is same as... (Question 4)	<ul style="list-style-type: none"> <li>• General nursing program</li> <li>• Nursing and caring</li> <li>• Nursing and Prevention</li> </ul>	Caring	
Is a combination of...	<ul style="list-style-type: none"> <li>• Nursing and forensic science</li> <li>• Nursing, then forensic science</li> <li>• Caring and holism;</li> <li>• Holistic nursing and population health;</li> <li>• Holism and objectivity.</li> </ul>	Prevention	Multi- disciplinary
Is influenced by...	<ul style="list-style-type: none"> <li>• Affiliation agreement</li> <li>• Partnerships</li> </ul>	Should partnerships influence philosophy?	Dichotomy
PHILIOSOPHY of MASTERS PROGRAM			
Is...	<ul style="list-style-type: none"> <li>• Advanced Practice Nurse with forensic focus only</li> <li>• Clinical Nurse Specialists</li> </ul>	Caring	Nursing
Is not...	<ul style="list-style-type: none"> <li>• Criminologist</li> <li>• Investigator</li> </ul>	Custody Collection of Evidence	Multi- disciplinary



*Multidisciplinary.* Six educators stated that even though nursing was the core, forensic nurses work in a multidisciplinary context. Examples of data extracts were:

- It's predominantly nursing but, the philosophy that we have is that nurses work within a multidisciplinary context. And we have to understand the role of the other professions that are coming into that context and they have to understand the role that we have. (Q3-P02)
- Philosophically we believe that it's a very multidisciplinary collaborative program. That's very important for us. Even though nursing of course is, it's our core, and it's where they come from, but we want them to be much more comfortable working with lawyers, with judges, with expert witnesses, with forensic scientists. (Q3-P17)

*Combination.* Some educators said the philosophy of their course or forensic program was a combination of: nursing and forensic science; nursing, then forensic science; caring and holism; holistic nursing and public health; and holism and objectivity. When most educators said it was a combination, they clarified that nursing needed to be the primary focus or philosophical foundation.

- Nursing within multidisciplinary. (Q3-P02)
- Combination of caring and holism. (Q3-P03)
- Our philosophical base is holistic and a nursing base. (Q3-P05)
- Holism and population health. (Q2-P07)
- Nursing and many disciplines. (Q3-P07)
- Combination of the forensic sciences and nursing. (Q3-P08, Q3-P19)
- Some combination of holism and objectivity. (Q3-P15, Q4-P15)

#### *Philosophy of Forensic Nursing Is Not*

Some educators stated the antithesis or what the philosophy should not be. Some educators stated the philosophy of the forensic nursing or education should not be solely forensic science or solely the technical skills. One educator stated that she/he did not teach victim care or survivor care, that it was patient care.

- Not a criminologist or an investigator, not survivor care, not victim care in that we are not going into the criminal justice language of referring to the people we serve as victims. (Q3-P16, Q4-P16)
- Not victim or offender but the person. (Q3-P15, Q4-P15)
- Not just technical skills. (Q3-P12, Q3-P19)
- Not just forensic science. (Q3-P19)
- No philosophical base accepted. (Q3-P11, Q4-P11)
- I must admit that I'm not sure that since we've got numbers of different people who were part of the basic framework, that we didn't actually accept any particular philosophies and theories, other than the fact that we wanted to ensure that we were preparing nurses, to operate from a framework that forensic science was a natural extending part of the nursing process. It was the responsibility, philosophically, of forensic nurses as a servant of society. (Q3-P11, Q4-P11)

#### *Philosophy of Forensic Nursing Is Influenced By*

Some participants stated that their philosophy was influenced by affiliation agreements and unique partnerships, as to how and what courses were developed.

- Some of the philosophy behind the program, I think our course, the way it developed, kind of lent itself to our affiliation agreement that we've had with a particular federal forensic service. And so it is this unique partnership that has influenced how this course has developed. (Q3-P01)

#### *Constructed Connotations*

The findings of Question 3, Philosophical Base?" contributed to the main themes of the study (See Chapter Five, Findings):

- ❖ Knowledge Concepts to Include
- ❖ Knowledge Definition (Constructed)
- ❖ Factors Influencing
- ❖ Forensic Theoretical Model

#### ***Q4. Philosophical Base of Nursing Program***

Question Four asked if that philosophy was the same or different to their general nursing program? The philosophy of the forensic nursing educational programs was generally consistent with the goals and mission of the educator's college of nursing.

##### ***Philosophy of Forensic Nursing Is the Same As***

Twelve educators said the philosophical base was generally the same as the nursing program or their school of nursing. Examples of data extracts were:

- Same as nursing program/ school of nursing. (Q3-P03, Q3-P05, Q3-P07, Q3-P08, Q3-P10, Q3-P16)
- In the philosophy issue the core concept is parallel to that of general nursing, in the sense of caring and prevention come into to determine the truth. It's the same core concepts in philosophies of nursing, but added is the specific and special information that is drawn from the forensic sciences, from sociology and psychology. (Q5-P08)

##### ***Constructed Connotations***

The constructed connotations of Question 4, "Philosophical Base?" were the same as Question 3.

#### ***Q5. Unique Knowledge of Forensic Nursing***

Question Five asked the participants what the unique knowledge or content was of forensic nursing. In responding to this question some responders associated the word unique as meaning many things, such as: *different from*, *special*, or *forensic*. Some used "unique" in the same way that they used the adjective *forensic* or interchangeably with the term *forensic focus* (See Table 4.5. Question 5).

Table 4.5.

*Q5. Unique Knowledge of Forensic Nursing*

<i>Categories</i>	<i>Unique Knowledge</i>	<i>Themes &amp; Taxonomies</i>
Unique Knowledge of Forensic Nursing IS:	<ul style="list-style-type: none"> <li>• Forensic Focus of Care</li> <li>• Forensic Dual Roles</li> <li>• Forensic Populations (vulnerable)</li> <li>• Forensic Client (victim/offender )</li> </ul>	Knowledge Definition Knowledge Delineation Dual Roles Dual Populations
Is not...	<ul style="list-style-type: none"> <li>• Not unique</li> <li>• Not a list</li> </ul>	Concepts to Include taxonomy
Is a combination of...	<ul style="list-style-type: none"> <li>• Nursing Process and Scientific Process</li> <li>• Science and Art (humanity)</li> </ul>	Nursing paradigm Nursing Process - Constructed
Is both/and...	<ul style="list-style-type: none"> <li>• Care of victims &amp; offenders</li> <li>• Health and healing</li> <li>• Identifies and investigate</li> </ul>	Knowledge Dual
Is focused on...	<ul style="list-style-type: none"> <li>• Interview focus of patient</li> <li>• Cases “more likely” to go to court</li> </ul>	Knowledge Differentiated or Differential Knowledge
Is different...	<ul style="list-style-type: none"> <li>• Prepared differently</li> <li>• Practice with a different group</li> <li>• Different than Nursing</li> <li>• Different than Forensic Disciplines</li> </ul>	Knowledge Differentiated or Differential Knowledge
Are tasks (unique)...	<ul style="list-style-type: none"> <li>• Assessment (sexual assault exam, risk assessment) Photography,</li> <li>• Medication management, Evidence collection, Court testimony, Chain of custody,</li> </ul>	Knowledge Delineation Concepts to Include
Is same as...	<ul style="list-style-type: none"> <li>• Same as Nursing</li> <li>• Same as other Forensic Disciplines</li> </ul>	Needed Knowledge Knowledge Needed

*Unique Knowledge of Forensic Nursing Is*

The educators responded to this question in a variety of ways. Many educators cited *concepts to include* or *tasks and skills* that were unique to forensic nursing.

Examples of data extracts were:

- The things that are uniquely forensic, I think are those things that stem directly from forensic medicine, or forensic science, for example the concepts of evidence collection, documentation and steps in investigation and analysis. (Q5-P11)
- Certainly some of the unique tasks of nursing are different from other disciplines for example, medication administration and supervision and

evaluation of the impact of medication. Some of these assessments the nurses might do particularly in the physiological domain are unique to nurses. (Q5-P01)

- Nurses use photography, and that's debatable if that's unique to nursing. (Q5-P11)
- A big component is the documentation and collecting of evidence. The technical aspects of preserving the chain of custody are things are not necessarily in the other nursing courses. (Q5-P05)
- So it's not a list of stuff. It's the process, and the, the whole machinery that we put it through. (Q5-P10)

#### *Unique Knowledge of Forensic Nursing Is NOT*

One participant said the unique knowledge was not a list of concepts, but rather the process. One example from the data extracts was:

- So it's not a list of stuff. It's the process, and the, the whole machinery that we put it through. (Q5-P10)

Another response was that forensic nursing was not unique but that it was simply giving nursing care to a population that had common problems of legal parameters. One example from the data extracts was:

- I don't think there is anything unique about forensic nursing. I think that this type of nursing is just a sub-specialty, dealing with populations that have something in common, and that something in common has to do with some sort of legal parameter, but providing care for these individuals is nursing. It's within the profession of nursing, we're bringing in legal parameters. We're advancing nursing knowledge in that we are taking information from another discipline and incorporating it into our practice. (Q5-P07)

#### *Unique Knowledge of Forensic Nursing Is a Combination Of*

Some educators stated that the unique knowledge of forensic nursing was a combination of knowledge or concepts. Examples from the data extracts were:

- It's a combination of the nursing process and the scientific process. We've got a combination of the science part and the humanity part. (Q5-P11)

### *Unique Knowledge of Forensic Nursing Is Different*

Some educators used the word *unique* to mean *different*. Examples of data extracts were:

- Forensic nurses are prepared in a different way. We have scientific knowledge, legal knowledge, nursing knowledge, and knowledge from other practice's too, that we know how to work with others collaboratively to enhance the care of the patient. (Q5-P17)
- Forensic nursing is unique in that we practice with a different group of collaborators in relationship to the patient. (Q5-P17)

### *Unique Knowledge of Forensic Nursing Is to Focus More Likely On*

Some educators clarified stated how the *focus* of forensic nursing was different in that forensic nursing was *more likely* to focus on certain things. Examples of data extracts were:

- Forensic nursing is different from nursing in general by the fact that we are more likely to rely on knowledge from the discipline of law, and forensic science. (Q4-P07)
- Forensic nursing is where nurses work with patients, who have a high likelihood of interfacing with one of the justice systems, whether that be a civil justice system or a criminal justice system. (Q1-P16)

### *Unique Knowledge of Forensic Nursing IS Same As Nursing*

Some educators described how the unique knowledge of forensic nursing was the same as *nursing* in general, and the same as other *forensic disciplines*. Examples of data extracts were:

- The unique knowledge and concepts include crisis intervention {which is also included in non forensic courses} victimology, theories of violence, forensic epidemiology, and defining and developing role as. So some of those may be included in nursing. (Q5-P03)
- Court room testimony may or may not be included. (Q5-P19)

- And I think one other concept that is somewhat unique to forensic nursing and to forensic medicine is thinking about the body as the crime scene. (Q5-P11)
- Although I do recognize that nursing isn't the only discipline that calls itself a caring discipline. But I mean that has been our contribution in many regards. But it's unique. (Q5-P01)

### *Constructed Connotations*

The responses generated from the Unique Knowledge question evolved into many of the main knowledge themes of this study: (See Chapter 5, Findings Knowledge Themes):

- ❖ Knowledge Delineation (described)
- ❖ Knowledge Needed /Knowledge Concepts to Include
- ❖ Knowledge Differential
- ❖ Knowledge Dual (Dual Roles)

### ***Q6. How Nurse Educators Gained Knowledge of Forensic Specialty Area***

In Question Six, the participants were asked how they gained their knowledge of this specialty for the purpose of course development to determine the source of their knowledge. The responses to this question were compared to the email survey that asked some specific questions about if they had taken forensic related or forensic nursing courses. A sample of n=17 was used for survey responses and n=16 for the Interview responses. (See Table 4.6, Question 6).

See Phase I of this Data Analysis chapter for the email survey findings and the data extracts relating to how educators gained their knowledge through number of years teaching nursing and forensic nursing, personal clinical practice experience in nursing and forensic nursing, and taking forensic related and forensic nursing courses for credit.

Table 4.6

*Q6. How Educators Gained their Knowledge*

<i>Categories</i>	<i>Years and Percentages</i>
<i>From Email Survey: n=17</i>	
S3. Number of years of clinical nursing experience	1-35 years
S3. Number of years of clinical forensic nursing experience	0-29 years
S8. Number of years of experience teaching nursing	0-42 years
S8. Number of years of experience teaching forensic nursing	3-29 years
S.5 Education - Took Forensic Courses for Credit	n=14/17 (82.4%)
S.5 Education - Took Forensic Nursing Course for Credit	n=12/17 (70.6%)
<i>Phone Interview: n=16</i>	
Clinical experiences	n=16/16 (100%)
Professional clinical practice experts	n=11/16 (68.8%)
Literature publications	n=11/16 (68.8%)
Forensic disciplines	n=6/16 (37.5%)
Research to date	n=6/16 (37.5%)
Professional associations	n=5/16 (31.2%)
Conferences	n=5/16 (31.2%)
Clinical teaching supervising students	n=3/16 (18.8%)
Forensic nursing courses already written	n=3/16 (18.8%)
Other sources ( <i>journal review, volunteer, military, colleagues</i> )	n=1/16 (6.25%)

*Clinical Experience*

Clinical experience was the most prominent category, which included the following: personal clinical experience in the forensic nursing area(s), clinical personal experience in other nursing areas, clinical experience that involved court room testimony, and clinical supervision of students in the forensic clinical area. Examples of data extracts of clinical experience were:

- Clinical came first which is the impetus for finding out more information, either through conferences or workshops, or articles, or whatever.  
(Q6-P10)
- Of all of those, I think my personal clinical experience is the main one.  
(Q6-P17)



- For me clinical experience. (Q6-P19)

The personal experience of court room testimony was identified as a role that was not usually gained through the undergraduate baccalaureate or graduate program. The reason was that as not everything can be included in the curriculum, and court room testimony was beginning to be considered a specialty concept. Examples of data extracts were:

- But you know what really stimulated it. Was on, on the stand having to explain, in court what it was that I was doing. (Q6-P19)
- So the court for me became the testing grounds. Publications gave it to me but only to create more questions. And forensic nursing now is, it's pretty much just validating my clinical experience. (Q6-P19)
- Not just clinical experience, but also experience testifying. (Q6-P20)

### *Educational Courses*

Regarding the category of Educational Courses, the responses varied from (n = 14/17) who took forensic (science) courses, and (n = 12/17) who took forensic nursing courses, and general graduate courses, where they were able to focus their paper assignments on forensic areas of interest. One educator said that she thought it was important that she had the same knowledge that students were required to have. Examples of data extracts were:

- I went to law school, so I spent three (3) years studying law? And already having the background in nursing. (Q6-P07)
- Primarily, I would say most of it, came from advanced courses within the Academy of Forensic Sciences. (Q6-P11)
- And so I did take those courses, the first year we started the program. It was very important that I had that knowledge as well as the students. (Q6-P17)
- But then I formalized that through a certificate in forensic nursing. (Q6-P02)

### *Experts in the Forensic Area*

Many educators acknowledged that they gained their knowledge through experts in the area and through the professional association of IAFN where they had the opportunity to associate with many expert nurses in the forensic specialty. Many names of known experts in the areas of forensic science and forensic nursing were mentioned by (n = 11/16) of the respondents. Examples of data extracts were:

- Provincial collaboration by SANE clinical experts. (Q2-P12)
- Also talking with some of the colleagues who have created programs throughout the country prior to the one I created. (Q2-P16)
- I think that working with experts has been the thing that has helped broaden my understanding of forensic nursing. (Q6-P17)

### *Literature /Publications*

As noted in the Literature Review in Chapter Two, there were few publications and literature on the role of forensic nursing when some of the first courses were developed. In this study the educators (7/16) who developed the very first courses stated that there were few publications as a resource when they developed their first courses.

Examples of data extracts were:

- Publications, well there wasn't when I started. (Q6-P08)
- There were very few publications. (Q6-P19)
- Initially there weren't any publications. (Q6-P20)

The remaining educators (n = 9/16) identified the literature as a resource to them gaining knowledge which included published articles and research literature. Also reading was included in this category as some educators stated that they read. A few stated that they first read and studied from the forensic science literature. Examples of data extracts were:

- Basically hunting the library and obtaining absolutely everything I could about forensic nursing. (Q6-P09)
- There were forensic sciences textbooks on forensic science, death investigations, forensic health sciences and, and sexual assault. (Q6-P09)
- And yes, there were some initial articles out there on correctional nursing, and forensic psych. (Q6-P10)

### *Forensic Disciplines*

Six participants identified knowledge from other forensic disciplines as a source of knowledge. Examples of data extracts were:

- And then I saw the need to expand, really the base of nursing knowledge, to include victimology, and that's how I did it. (Q6-P03)
- And so much of it came from forensic psychiatry, forensic psychology, and, areas such as forensic toxicology. (Q6-P06)
- Books on forensic science, death investigations, forensic health sciences and, and sexual assault....(Q6-P09)
- Forensic science, forensic psych, criminology courses shaped forensic nursing. (Q6-P11)

### *Research in Forensic Nursing*

Six participants mentioned research in forensic nursing to date. One example of an extract was:

- I also used a lot of research literature, but not necessarily from forensic nursing because when I started writing this these courses there was very little available, and so much of it came from forensic psychiatry, forensic psychology, and areas such as forensic toxicology. (Q6-P06)

### *Professional Associations and Conferences*

Five participants each acknowledged that they gained their knowledge through membership in professional associations and attending conferences. Examples of data extracts were:

- But more importantly by core competencies or identified areas of expertise that professional associations were addressing, such as the IAFN,

requirements for sexual assault nursing examiner course or, standards of care, with, through emergency nursing ....and American...and Canadian emergency nursing associations. (Q6-P02)

- I would say that probably sixty per cent of it has come from the Academy. (Q6-P11)
- A lot of the knowledge that I've gained over the years has been experience through the Custody & Caring Conference. (Q6-P01)
- But most of them I've gotten through workshops, seminars, or short courses offered by either the Academy of Forensic Sciences or by IAFN. (Q6-P11)

#### *Previous Courses in Existence*

Some educators said that they had the opportunity to review a variety of forensic nursing course outlines already in existence at other universities. The syllabus and information with regard to resources they stated was information that helped them gain their knowledge of what content to include. Examples of data extracts were:

#### *Previous Forensic Nursing Courses Already In Existence*

- Internet search on every program from...and so I have a binder for everything...that I continually added to a binder of course outlines and articles from journals. (Q6-P09)

#### *Clinical Teaching/Supervising Students*

Clinical teaching and supervising students was mentioned by (n=3/16) respondents. The distinction between the participants' response of their direct clinical nursing practice experience and the clinical teaching or supervision of students was clarified in the telephone interview because some participants counted their direct supervision of students as being one in the same as their direct clinical practice experience. This point is noted in the following data extracts from the qualitative interview. Examples of data extracts were:

- But it has been experience through my clinical teaching with undergraduate and post RN and to a smaller degree graduate students, who

are working in the forensic area and how knowledge is applied to that particular setting and the kind of knowledge that is necessary in order to practice at those different levels. I guess that's how I came to acquire my knowledge. (Q6-P01)

- I have almost, well more than 10 years of clinical teaching in the area with students so inside that time I identified where they had unique questions or knowledge gaps. (Q6-P01)

### *Other Sources*

Other sources were journal review, working as a volunteer in a women's shelter, courses in the military, and talking to other colleagues (n = 01/16). Examples of data extracts of other sources of how educators gained their knowledge were:

- And then going on to ...journal review. (Q6-P02)
- In the military it was very easy to enroll in those kind of courses. So some of them I got while I was actually on duty in the military. (Q6-P11).
- Or by some local university through Continuing Education. (Q6-P11)
- I worked as a volunteer within a battered women's program and a battered women's hotline. (Q6-P16)
- Also talking with some of the colleagues who have created programs throughout the country prior to the one I created. (Q2-P16)

### *Combination*

Most of the respondents identified a combination of many things that helped them to gain their knowledge. Examples of data extracts were:

- A combination of my own experiences with caring for victims of violent acts, and the readings that I've done over the years. (Q6-P05)
- I made the course a combination of my clinical experiences running hospital based family violence intervention programs and sexual assault programs, but I also based the content on nursing literature. (Q2-P16)

### *Constructed Connotations*

It was most evident from the responses to this question that sources of knowledge were not limited to only one source of knowledge area or one response. As expected, the

respondents with the least amount of clinical forensic nursing or general nursing experience, themselves said they drew on other sources for their knowledge. Some who had minimal clinical personal experience were ones that drew on their clinical experience of supervising students, attending conferences, and the available literature. Some educators did not distinguish between personal clinical experience and teaching clinical experience, and felt that it was one in the same. Others who had been some of the first to develop courses drew on the forensic sciences, either from taking courses, or from experts in the area. Some listed many other forensic nurses who they attributed as a source, while others claimed to be depend more on self-study and reading. All participants wanted to qualify that all their past nursing experience had some aspects that were related to forensic nursing, and most had clinical experience in identified forensic nursing areas.

#### ***Q7. Nursing in the Title and Concepts to Include***

During the phone interview, participants were asked if nursing was in the title of the courses or programs they developed. Throughout the database nurses often stated concepts that were important to include in forensic nursing curricula.

##### *Nursing in the Title*

The finding in this study was that the participants did include *nursing* in the title of the courses in 64.7% of the courses listed. Example of data extracts were:

- The title of the program was originally meant to be *Forensic Nursing*, but when we kept nursing in the title, we found that other professions such as the lawyers and, the police officers that could benefit from the courses... were not taking it because they felt it was just nursing courses, and they wouldn't be allowed. So it was more of a marketing issue. The Program is called Forensic Studies and we still have approximately 80% nurses in the program. (Q2-P02)

- Advanced specialty certificate in forensic health care, housed in the forensic science department. It's a program of its own? (Q3-P09, Q4-P09)

From the findings of this study, it could be argued that some programs are influenced by market demands and administrators that do not strongly support the *nursing* part first in the programs. Administrators may have been co-opted by the belief that the *sell* of the program would be through the legal aspects or the forensic aspects of the program, rather than the *nursing* part of it. Therefore, the term *nursing* is left out of the title.

#### *Concepts to Include*

Participants were not specifically asked what concepts to include in the forensic nursing programs, but in the process of responding to the other questions in the survey and in the phone interview, they often mentioned concepts they felt were important to include in forensic nursing course curriculums. In the email survey the participants were asked to provide the titles of the courses that they have developed themselves (S6 of the email survey), and the titles of the forensic nursing courses at their institution (S19 of the email survey) (See Appendix D2 and D4 for complete lists of S6 and S19 of Forensic Nursing Courses and Programs developed by this sample of participants and programs offered by their universities).

In addition to determining the number and type of course developed the reason for the list was to determine a collective analysis of concepts to include by examining the titles of the courses and the concept names of the modules.

### *Constructed Connotations*

As part of the analysis of this study, I constructed a list or taxonomy of concepts from the total course data, the titles of the forensic nursing courses and units of study offered at the participant's institutions. The result was a Taxonomy of Forensic Nursing's Knowledge Concepts to Include in forensic educational courses (See Appendix D5--Taxonomy of Knowledge Concepts to Include). Question 7 of "Nursing in Title and Concepts to Include?" resulted in findings further described in Chapter Five

### ***Q8. Most Satisfying About Developing and Teaching Forensic Nursing Courses***

The *most satisfying* question was added to the questionnaire after the first interview because it elicited some rich data when asked informally. The data for Questions 8-13 seemed to fall into the obvious *Themes of Positive and Negative Influences*. The data for this question was divided into subthemes of what was most satisfying about developing and teaching forensic nursing courses, and what was least satisfying about developing and teaching forensic nursing courses. The subcategories for each category were represented by various descriptors as indicated in the table (See Table 4.8. Question 8).

### *Most Satisfying--Positive Factors*

The educator's perception of what was most satisfying about developing and teaching forensic nursing courses was significant to this study. The most satisfying theme was represented by five main categories: the student, the educators themselves, the specialty of forensic nursing, the multidisciplinary aspects, and the patients.



Table 4.8.

*Q8: Most Satisfying/Least Satisfying*

<i>Most Satisfying (Positive Influence)</i>	<i>Least Satisfying (Negative Influence)</i>
<i>Students</i> <ul style="list-style-type: none"> <li>• Enthusiasm</li> <li>• Awareness</li> <li>• High enrollment</li> <li>• Roles/careers</li> </ul>	<i>Students:</i> <ul style="list-style-type: none"> <li>• Lack of enthusiasm</li> <li>• Sensationalism</li> <li>• Victimization disclosure</li> </ul>
<i>Educators</i> <ul style="list-style-type: none"> <li>• Enthusiasm</li> <li>• Forensic educator role</li> </ul>	<i>Educators</i> <ul style="list-style-type: none"> <li>• Lack of resources</li> <li>• Lack of admin support</li> <li>• High workload</li> <li>• Travel</li> </ul>
<i>Specialty</i> <ul style="list-style-type: none"> <li>• Acceptance by nursing</li> </ul>	<i>Specialty</i> <ul style="list-style-type: none"> <li>• Lack of acceptance by nursing</li> <li>• Lack of understanding</li> <li>• Non supportive physicians</li> </ul>
<i>Other Disciplines</i> <ul style="list-style-type: none"> <li>• Medicine was first to be supportive</li> </ul>	<i>Other Disciplines</i> <ul style="list-style-type: none"> <li>• Non supportive physicians</li> </ul>
<i>Patients</i> <ul style="list-style-type: none"> <li>• Improved Care</li> </ul>	<i>Patients</i> <ul style="list-style-type: none"> <li>• None known</li> </ul>

*Student.* Outcomes that were the most satisfying to educators developing and teaching forensic nursing courses with regard to their students was the enthusiasm of the students, the high enrollments, and the fact that they were getting forensic nursing roles as a result of this education. Examples of data extracts were:

- The enthusiasm of the students and knowing that they're going out there and starting programs after the training! (Q8-P20)
- Taking a group of students and introducing them to the concepts, and the special aspects of forensic nursing, like sexual assault, violence, child abuse, death investigations, forensic psychiatric nursing. (Q8-P09)
- Our nursing graduates are getting advanced practice positions in hospitals and clinics. (Q8-P17)
- Some of the graduates have been hired. Their role within the agency, or hospital or clinic they work in has been expanded because of their forensic knowledge. Feedback from the agencies about the value of the forensic

nursing program and now they hire our nurses as consultants when they have a case. (Q8-P03)

*Educators.* For the educators, the most satisfying thing has been the enthusiasm they have for introducing a new discipline to the students and also that it has resulted in full time faculty or forensic coordinator positions for themselves. Examples of data extracts were:

- Being able to stay current on the knowledge development in all of forensic nursing. (Q8-P06)
- Full time forensic teaching position. (Q8-P06)
- Between being the chair, as well as, being the developer of the online courses. I get to, to live in it. (Q8-P06)

*Acceptance from other disciplines.* The educators also felt it was satisfying to have the acceptance from other nurses and other disciplines, and one participant noted that medicine as a discipline was the first to be supportive. Examples of data extracts were:

- The greatest support has always come first from medicine. (Q8-P08)  
before being accepted by nursing, isn't that interesting? (Q8-P08)
- The cross discipline nature of my classes. (Q8-P15)
- We were teaching residents and nurses about sexual assault, domestic violence, elder abuse, all kinds of stuff. (Q8-P19)

*Acceptance as a specialty.* The educators noted it was satisfying to have forensic nursing accepted as a nursing specialty. Examples of data extracts were:

- The idea that the forensic principles become core to general nursing curriculum embedded in their practice. (Q8-P02)
- Having forensic nursing accepted as a specialty. (Q8-P08)
- Seeing where the forensic nursing sexual assault nurse examiners much more readily accepted in the court system as experts, which prior to the SANE program we actually weren't. (Q8-P12)

*Patients.* Another satisfying thing as a result of forensic nursing and educational courses has been the improved care that has been provided to the patients, and the increased conviction rates in court. Examples of data extracts were:

- The patient is benefiting so I would say that is the most satisfying thing and the care is better. (Q8-P07)
- The service to sexual assault victims is better, same with domestic violence. (Q11-P12)

*Least Satisfying- -Negative*

Participants also identified *least satisfying* factors with regard to developing and teaching forensic nursing courses. The same categories also yielded negative factors.

*Students.* Outcomes that were the least satisfying to educators developing and teaching forensic nursing courses was a lack of curiosity and enthusiasm among their students. Also educators did not like to see the students get caught up in the sensationalism of the media and think that was what forensic nursing was all about. One educator stated that it was difficult in that she knew every time she taught large class on sexual assault that she would have students disclosing their own experiences of sexual abuse. Examples of data extracts were:

- Some students don't have the same enthusiasm or the same level of curiosity. (Q8-P06)
- When students get caught up in the sensationalism of the setting, the crime or the patient. (Q8-P01)
- When students struggle with their professional boundaries. (Q8-P01)
- The exposure of victimization. People come to these courses, and bless their hearts they're victims it's the knowing that every time I teach the course I'm gonna to have some type of disclosure. (Q8-P19)

*Educators.* For the educators themselves what was *least satisfying* was lack of administrative support, lack of instructional resources, high workload, and the amount of travel required. Examples of data extracts were:

- When you're an administrator and you get no help from the top when trying to keep the program a float. (Q8-P19)
- Workload has increased tremendously. (Q8-P17)
- Sheer volume of the course /program content due to multidisciplinary as well. (Q8-P02).
- The numbers game having 250 people in every class is very hard. When it comes to evaluating them and marking their paper assignments. (Q8-P15)
- Travel, having to be away from home, long nights in hotels. (Q8-P20)

*Lack of acceptance.* Participants shared that lack of acceptance of the forensic nursing specialty by other nurses was difficult, and as well, the resistance shown by some physicians to the program. Examples of data extracts were:

- Lack of acceptance by nursing itself in the beginning. (Q8-P08)
- Misunderstanding even after explanations. (Q8-P05)
- Some people just don't want to change. (Q8-P07)
- When other disciplines don't feel it was an appropriate place for students. (Q8-P05)
- When pathologist, coroner see no place for nurses in forensic practice. (Q8-P07)

*Combination.* Participants stated there were times when it was both satisfying and not satisfying or positive and negative outcomes at the same time in the process or developing and teaching this specialty. Examples in the data were

- Most and least satisfying in teaching forensic nursing was the two extremes, one county was more than happy, welcomed our students and provided a wonderful experience while another county absolutely refused to have them. (Q8-P05)
- It is satisfying now after taking the SANE program that nurses are very happy and satisfied professionally in their role, so they actually get to use the skills and knowledge they have in an appropriate way, versus, they

have all this knowledge but they need to wait and call the physician to come in and do an internal on the person. (Q8-P12)

### *Constructed Connotations*

This *most satisfying* question proved to be significant because it elicited outcomes of forensic nursing educational programs in terms of benefits for the students, the faculty, the specialty, and especially how the patients benefited. Participants when responding to this question commented on the benefits of forensic nursing education for patients and its assistance in changing attitudes and practice roles of forensic nursing. When articulating what was most satisfying and least satisfying, the acknowledgment of the existence of both the positive and negative influence theme together represents the constructivist world view or a both/and connotation. The responses generated from the Most/Least Satisfying question evolved into many of the points cited in *Implications for Practice and Education* included in the final chapter of this study. (See Chapter 6, for Practice Implications).

### ***Q9. Organizations Foster New Specialty Educational Development***

In Question Nine the participants were asked how organizations *fostered* new specialty educational development. From the main theme of Positive and Negative Influences, the data was divided into sub-themes of how organizations *fostered* new specialty educational development, and how organizations have *not fostered* new specialty educational development? (See Table 4.9. Question 9).

Table 4.9.

*Q9. Organizations Foster/Not Foster*

<i>Organizations Foster/ did Foster? (Positive Influence)</i>	<i>Organizations did Not Foster? (Negative Influence)</i>
<i>Governments</i> <ul style="list-style-type: none"> <li>• US Gov (grants, policies, programs)</li> </ul> <i>Forensic Systems/ Services</i> <ul style="list-style-type: none"> <li>• Partnerships, agreements</li> </ul> <i>Health Care System</i> <ul style="list-style-type: none"> <li>• Funding, training, tuition, time off</li> <li>• Encouraged education</li> </ul> <i>Publications/Journals</i> <ul style="list-style-type: none"> <li>• JEN, JPN, JFN</li> <li>• Widespread dissemination</li> </ul> <i>Professional Associations</i> <ul style="list-style-type: none"> <li>• IAFN, ENA, ANA</li> <li>• IAFN deserves the most credit</li> </ul> <i>Community Groups</i> <ul style="list-style-type: none"> <li>• Woman's Groups' agencies supportive</li> </ul> <i>Other Forensic Disciplines</i> <ul style="list-style-type: none"> <li>• Support for scope of role</li> </ul> <i>Nursing Discipline</i> <ul style="list-style-type: none"> <li>• Leaders, pioneers in professional associations</li> </ul>	<i>Governments</i> <ul style="list-style-type: none"> <li>• US Gov (no grants, no funding)</li> </ul> <i>Forensic Systems/ Services</i> <ul style="list-style-type: none"> <li>• Skepticism</li> </ul> <i>Health Care System</i> <ul style="list-style-type: none"> <li>• No funding, no training, no tuition, no shift replacement</li> <li>• Discourage graduate education as takes away from the bedside</li> </ul> <i>Publications/Journals</i> <ul style="list-style-type: none"> <li>• JEN, JPN, JFN</li> </ul> <i>Professional Associations</i> <ul style="list-style-type: none"> <li>• Many nurses do not participate</li> </ul> <i>Community Groups</i> <ul style="list-style-type: none"> <li>• Skepticism</li> </ul> <i>Other Forensic Disciplines</i> <ul style="list-style-type: none"> <li>• Barrier for scope of role</li> </ul> <i>Nursing Discipline</i> <ul style="list-style-type: none"> <li>• Need for leadership</li> </ul>

*Organizations Fostered--Positive Factors*

Eight main categories of how organizations fostered forensic nursing course development were selected after reading through the data. From the participant's perspective the main fostering areas were: government departments, systems/services, professional associations, publications/journals, health care organizations, communities/groups, other forensic disciplines, and the nursing discipline.

*Government.* Results were that government funding and policies have fostered educational development in the building of affiliations and partnerships with federal systems. Examples of data extracts were:

- For all that's wrong with the current US administration (2006), they've given more money to victims of violence, than all the previous ones combined. They have provided education for nurses, to the tune that has not seen before. (Q9-P19)
- The grants that support this stuff are wonderful. (Q9-P19)
- Unique affiliation agreement between Correctional Services, Forensic Psychiatric Treatment Services and the university. (Q9-P09)
- The law enforcement and the judicial system... And the forensic laboratory services were supportive beyond belief. (Q9-P09)

*Health care system.* Funding, training, tuition, and time-off were provided by the health care system. Examples of data extracts were:

- Some hospitals will pay the tuition if the student, if the nurse will take the course. (Q9-P13)
- Hospitals recognize in order to have a program that nurses have to get educated. Some of them it's funded the nurses going to the training programs, and funded the training. That's probably been how they fostered it. (Q9-P20)

*Professional associations.* Of all the professional associations, the International Association of Forensic Nurses (IAFN) was given the most credit. The Emergency Nursing Association and the American Nurses Association were also noted for promoting educational development. The ANA was helpful in approving forensic nursing as a specialty, when specialty status was initiated by the IAFN members. Examples of data extracts were:

- Of all the different organizations, IAFN deserves the most credit. Secondarily the Emergency Nurse's Association has, given some validity to forensic nursing um, in it's publications, in it's committee structure. (Q9-P16)

- And then finally the American Nurses Association has in 1995 when they ...acknowledged forensic nursing as a specialty not a sub-specialty, that gave some policy political justification to this as a specialty. (Q9-P16)

*Nursing journals.* Certain journals in particular provided widespread dissemination of forensic nursing articles and research; The Journal of Emergency Nursing, the Journal of Psychiatric Nursing, the Journal of Forensic Nursing, and the Forensic Magazine were the ones mentioned most often. Examples of data extracts were:

- The Journal of Emergency Nursing, which is part of the Emergency Nursing Association does, did have the forensic nursing and the SANE nursing column for many years. (Q9-P20)

*Community agencies.* Women's groups and other community agencies had an interest in forensic nursing' endeavors. Examples of data extracts were:

*Communities & Groups--Fostered*

- Women's groups have supported it. (Q9-P02)
- The interest in forensics came from the community, the hospital and the district. They asked us for a forensic educational course. (Q9-P13)
- The students whom go to get the education for SANE courses, find support because the hospitals and communities see this is going to be a benefit and that they can be looked at as the good guy. And so it's money well spent. (Q9-P19)

*Forensic disciplines.* Other forensic disciplines of law and law enforcement, (i.e., the crown and the police) supported the full scope of the role development of forensic nursing. Examples of data extracts were:

- I had a network and the prosecutor at the time was an incredible advocate. (Q9-P03)
- The crown thought it was great. The police thought it was great. (Q9-P12)



*Nursing discipline.* Within the discipline of nursing, many forensic nurses pioneered the role and the educational development of the specialty, and held leadership positions in the forensic professional associations. Examples of data extracts were:

- Well certainly you can't give enough credit to some of the early leaders of the IAFN, as far as really pushing forensic nursing into mainstream, not only clinical practice, but also pushing it into mainstream academia. (Q9-P16)

*Organizations Not Fostered--Negative Factors*

When the data was sorted, the participants also had collectively voiced areas of non support. The same areas that for some had fostered forensic nursing educational development, for others had been the source of non fostering or a negative impact.

*Government.* Results of the have *not fostered* sub-theme were that some areas did not receive needed government grants, funding, or policies to foster forensic nursing. One example was:

- For a long time government did not foster it- after 911 they did. (Q9-P11)

*Community/ groups.* There also was a certain degree of skepticism by some judicial systems and skepticism from some key community groups and agencies.

Examples of data extracts were:

- My contact in various areas of law enforcement and community agencies initially met with some skepticism. (Q9-P03)

*Professional associations.* Although professional associations have often fostered specialty and educational development, many nurses do not participate in professional associations, and some professional conferences are not well attended. Examples of data extracts were:

- In this country I don't find that nurses, a large percentage of nurses participate in their nursing organizations, and to me that's quite sad. (Q9-P07)

*Health care organizations.* With the nursing shortage, many health care systems were not giving nurses time off or the funding to take courses, or did not provide shift replacement. In fact, some health care employers discouraged graduate level education because increased education often resulted in the nurse leaving the bedside. Examples of data extracts were:

- The health care organizations were no support what-so-ever, the hospitals were even worse. (Q9-P09)
- Most organizations have been a hindrance, because students that are going back to school generally are seen as a threat to the establishment and many of them have had to leave, or alter their relationship with their employers. (Q9-P19)

*Other disciplines.* Finally, the forensic role was sometimes met with resistance and barriers by other disciplines, especially if the scope of the role was perceived to be infringing on their professional or organizational territory. Examples of data extracts were:

- The police would say "So why don't you just be the nurse, and let me be the cop... Why are you trying to be the cop? So we had a bit of resistance initially, but not now." (Q9-P03)
- We had lots of opposition, and I think most places have, mostly from physicians, who said that we didn't have the skill and knowledge to become an expert. (Q9-P12)
- Sometimes it has been the physicians who really don't want to support the nurses. It hasn't been the institutions. It's been physicians within the institutions. (Q9-P20)

*Resistance.* Some educators noted that when the specialty was in its early years there was a lot of resistance from many sources, but over time that has decreased.

Examples of data extracts were:

- At first it was like chipping away at a mountain with a toothbrush. Initially a bit of resistance, skepticism, not now. (Q9-P03)
- The police would say “So why don’t you just be the nurse, and I let me be the cop” Why are you trying to be the cop?”. So we had a bit of resistance initially – but not now. (Q9-P03)

### *Constructed Connotations*

Both fostering factors and non fostering factors from organizations were the collective perspectives from the participants as to influencing factors with regard to forensic nursing educational development. There was a general consensus that historically this has changed from negative to positive. The responses generated from “Organizations Fostered/Not Fostering” question contributed to the main *Factors Influencing* themes of this study (See Chapter 5, Findings--Factors Influencing).

#### ❖ Positive and Negative Factors Influencing Theme

### ***Q10. Institutions of Higher Learning Support New Specialty Educational Development***

In Question 10, the participants were asked how *institutions of higher learning* supported new specialty educational development in forensic nursing. From the main theme of Positive and Negative Influences, the responses were divided into sub-themes of how educational institutions have supported new specialty educational development, and how educational institutions have not supported new specialty educational development. (See Table 4.10. Question 10).

Table 4.10.

*Q10. Institutions of Higher Learning Supportive/Not Supportive*

<i>Educational Institutions Supportive (Positive Influence)</i>	<i>Educational Institutions Non Supportive (Negative Influence)</i>
<i>University/College</i> <ul style="list-style-type: none"> <li>• Forensic Focus /Niche</li> <li>• Market Niche</li> <li>• Funding</li> </ul>	<i>University/College</i> <ul style="list-style-type: none"> <li>• Resistance, skepticism</li> <li>• Do not support</li> <li>• Do not understand</li> <li>• Do not market the program</li> </ul>
<i>Nursing Schools/ Departments/Colleges/Faculty</i> <ul style="list-style-type: none"> <li>• Increase in programs nationally</li> <li>• Trend</li> <li>• Graduate forensic nursing programs</li> </ul>	<i>Nursing Schools/ Departments/Colleges/Faculty</i> <ul style="list-style-type: none"> <li>• Housed in forensic science not in nursing</li> </ul>
<i>Administrators</i> <ul style="list-style-type: none"> <li>• Supportive now as trend &amp; popular</li> <li>• Support forensic faculty positions</li> </ul>	<i>Administrators</i> <ul style="list-style-type: none"> <li>• Trend &amp; popularity will not last</li> </ul>
<i>Curriculum/ Electives</i> <ul style="list-style-type: none"> <li>• Advanced practice</li> <li>• DNP Programs</li> </ul>	<i>Curriculum/ Electives</i> <ul style="list-style-type: none"> <li>• No Electives/</li> <li>• No room in curriculum</li> </ul>
<i>Online Education</i> <ul style="list-style-type: none"> <li>• Assist faculty shortage</li> <li>• Faculty from afar can develop/teach</li> </ul>	<i>Online Education</i> <ul style="list-style-type: none"> <li>• Not supportive of online</li> </ul>
<i>Students/Nurses</i> <ul style="list-style-type: none"> <li>• Demand, request for more education</li> </ul>	<i>Students/Nurses</i> <ul style="list-style-type: none"> <li>• n/a</li> </ul>
<i>Individual Nurses/Educators</i> <ul style="list-style-type: none"> <li>• Passion, drive, push, vision, leadership**</li> </ul>	<i>Individual Nurses/Educators</i> <ul style="list-style-type: none"> <li>• Credibility of educators questionable</li> </ul>
<i>Faculty Need/Shortage</i> <ul style="list-style-type: none"> <li>• Need</li> <li>• Growing their own</li> <li>• Future Faculty through the programs</li> <li>• Assist faculty shortage</li> <li>• Faculty from afar can develop &amp; teach</li> </ul>	<i>Faculty Need/Shortage</i> <ul style="list-style-type: none"> <li>• Shortage -Lack of skilled faculty</li> </ul>

*Educational Institutions--Supportive*

The participant/educators had viewpoints of how educational institutions had been supportive. After reading through the data, I found that the main *supportive* categories of

institutions of higher education were: University/College, nursing departments, administrators, curriculum/electives, online education, students/nurses, individual educators, and faculty needs or shortages.

*Administrators.* The result of the *support* sub-theme was that forensic nursing programs had been created in educational institutions. The participants felt that support from the administrators was key to programs being initiated. Similar data indicated that support seemed to be present once forensic nursing was understood. Examples of data extracts were:

- Accepted and promoted by our Dean, and then once she was onboard she pushed it through fairly rapidly. (Q9-P05)
- So once they understood it, it, they supported it, and fostered it a lot more. (Q10-P17)

*Nursing schools and departments.* Support occurred in the forms of financial funding, and the creation of faculty positions. For some educational institutions, the forensic program became the focus niche for their nursing department or for their university. Forensic tracks were created for their advanced practice and Doctoral Nurse Practitioner (DNP) programs. Examples of data extracts were:

- We have a slowly growing a number of universities and colleges who are beginning to create forensic nursing programs especially, advanced practice or master's level. (Q10-P16)
- Our President and Provost have issued an initiative that ...is one of our initiatives is to become a university that is known for its forensics in many different areas, and they support that in many different ways, financially and faculty-wise etc. (Q10-P17)
- So once they understood it, it, they supported it, and fostered it a lot more. (Q10-P17)
- The trend is now, is that virtually every master's forensic nursing in the U.S, is talking about having a doctorate of nursing practice and to me that's gonna change the face of forensic nursing. So the DNP is gonna

change the face of forensic nursing in the future, and there will be master's nurses. And they will be the experts in their arena. But I don't see them as being the leaders. I see the DNP as being the practice leaders. But the reality is there's over a hundred nursing schools in one year that are converting their nursing, master's programs to the DNP. (Q10-P19)

- Initially by having, the CEU programs based there, and then developing courses, and hopefully now developing, whole tracts. (Q10-P20)

*Student request.* Students calling the universities and asking if nursing had a forensic nursing program was another factor that supported the impetus for forensic nursing educational development. Examples of data extracts were:

- And I have had nurses calling us that are currently working in forensic facilities that feel they want need additional education to more effectively work in their role. (Q9-P01)

*Individual nurse educators.* The data indicated that forensic nursing courses and programs were established at specific college or university due mainly to the passion, drive, push, vision, and leadership of individual nurses. Some participants reported that they felt driven to write the courses: it was something they just had to do. Examples of data extracts were:

- The forensic nursing courses are there and survived because of the few passionate people there. (Q9-P15)
- I pushed for it for a good five years before it finally was accepted and promoted. (Q9-P05)
- Why they chose forensic nursing as opposed to a nurse practitioner program in gerontology is because of the passion of this sexual assault nurse examiner, faculty member. (Q9-P06)

#### *Educational Institutions--Not Supportive*

The participant/educators had point of view of how educational institutions had not been supportive. Again, they were easily sorted into the similar categories as those identified for the supportive sub-theme.

*Administrators.* The results of the *lack of support* sub-theme showed that when forensic nursing was not understood by educational institutions, stakeholders or administrators, it was not supported. Examples of data extracts were:

- The new Graduate Dean had a very negative perspective about forensic nursing. (Q13-P08)
- Our Dean, when we first started said this is just a flash in a pan. This is just people. This is unique for a year or two, and then it's going to lose what has happened. (Q10-P17)

*Nursing schools and departments.* Nursing colleges often had not accepted the idea of a separate course or program being developed, and individuals with the expertise, often were only welcomed and used as guest speakers. Therefore, some of the courses and programs were housed in forensic-science facilities rather than in nursing departments. Examples of data extracts were:

- Generally all the schools of nursing approached were not supportive in the least. (Q10-P09)
- It was really interesting because, several of them had actually asked me to do presentations on forensic... within a perhaps a general nursing course or the emergency specialty course, but the educational institutions, no one was interested in a separate course? Only as a guest speaker sort in a core course. (Q10-P09)
- None of the educational institutions were interested in nursing in forensic science, so that's is why the courses are housed in forensic science and not nursing. (Q11-P09)

*Universities/colleges.* Once a program was initiated, still some universities had not supported the forensic nursing programs in term of marketing, economic funding, or recognition. Examples of data extracts were:

- I don't think they have, I know that from my university there's not much public relations going on in really pushing the program, something that's at the university level. I don't see our university taking a big role. (Q10-P05)

- I'm not so sure that they're supporting them to the extent that would be more beneficial to the students that come in. (Q10-P05)
- Not very well, it's been an uphill battle. It took three to five years before anybody would consider it, here. (Q10-P09)
- And educational institutions they weren't really supportive at first either? In my case no the university here is not a forensic place. (Q10-P15)

*Curriculum*, In many cases “set” curriculums at a colleges or universities were not supportive of new specialty development as they did not allow flexibility. Curriculums were packed with core nursing courses with no room for electives or specialty courses.

Examples of data extracts were:

- And university programs that I have been affiliated with in terms of different curricula that have been in our program we had very little room for any specialized courses, let alone forensic courses. (Q10-P01)

*Popular trend, bandwagon effect*. It was thought that some universities may have started forensic nursing programs because of their popularity and the current trend emphasizing a market niche, but the credibility of the educators being granted responsibility to develop and teach the programs was questionable. Examples of data extracts were:

- I do have a fear however, that some universities may be starting forensic programs because they're a popular topic. Yet I'm unclear whether the faculty that are being chosen to teach it truly know what they're teaching (Q10-P16).

*Lack of qualified educators* There also was a lack of qualified educators to teach the forensic nursing programs. In some cases, colleges or administrators wanted to develop the program, but did not have qualified faculty to write and teach the programs.

Examples of data extracts were:

- Difficulty finding qualified nurses to write and teach it. (Q10-P06)



- There are only a handful of us truly, in North America who have a master's degree or higher and would be eligible to teach at the college and university level (Q12-P16).

### *Constructed Connotations*

Evidence in the form of data extracts showed support for both how educational institutions supported and did not support forensic nursing educational development.

The responses generated from the “Educational Institutions Supported/Not Supported” question contributed to the main *Factors Influencing* themes of this study (See Chapter 5 Findings – Factors Influencing).

### ❖ Positive and Negative Factors Influencing

#### ***Q11. Factors Influencing Forensic Nursing Specialty Educational Development***

##### ***(Social, Media, Economic, Technologic and Political)***

In Question 11, the participants who had the experience of writing and teaching forensic nursing courses were asked what social factors influenced this specialty educational development. Their responses were divided into categories of social, media, economic, technologic, and political factors. The main categories and subcategories were divided into positive and negative themes (See Table 4.11. Question 11).

Table 4.11.

*Q11. Influencing Factors--Positive and Negative*

<i>Category(s)</i>	<i>Subcategory(s)</i>	<i>Positive Themes</i>	<i>Negative Themes</i>
Social	<ul style="list-style-type: none"> <li>• Awareness of Violence in Society</li> <li>• Perception of Nurses in Society</li> <li>• Expectation from Society</li> <li>• Need - Specialty Forensic Nursing Education</li> <li>• Impact of the Media on Society</li> </ul>	See Table 4.11a	
Media	<ul style="list-style-type: none"> <li>• Entertainment Media</li> <li>• Public Information of High Profile Cases</li> <li>• Media Support of professionals</li> <li>• Media Advocate for Victims</li> </ul>	See Table 4.11b	
Economic	<ul style="list-style-type: none"> <li>• Cost Effectiveness of Forensic Practice Role and Forensic Nursing Education</li> <li>• Cost of Tuition</li> <li>• Role Compensation</li> </ul>	See Table 4.11c	
Technology	<ul style="list-style-type: none"> <li>• DNA Advanced Technology</li> <li>• CSI Phenomenon/CSI Effect</li> <li>• Education –Advanced technology of Online</li> <li>• Practice – Advanced technology tools)</li> </ul>	See Table 4.11d	
Political	<ul style="list-style-type: none"> <li>• Legislation/Policy Changes /Specialty Status</li> <li>• Power of emerging social priorities</li> </ul>	See Table 4.11e	

*Social Factors--Positive*

Positive social factors that influenced the forensic nursing educational development were: the awareness of violence in society, the awareness in society of forensic issues, the forensic trend, the need in society for a forensic role and education, and the social acceptance of nursing in society as a trusted and valued profession.

Examples of data extracts were:

### *Q11a. Social Factors*

Table 4.11a.

#### *Q11a: Social Factors--Positive and Negative*

<i>Social Facilitating Factors (Positive Influence)</i>	<i>Social Impeding Factors (Negative Influence)</i>
<i>Awareness of Violence in Society</i> <ul style="list-style-type: none"> <li>Public awareness, Societal trend, Forensic household word, Awareness of high schools students, High Profile cases</li> </ul>	<i>Awareness of Violence in Society</i> <ul style="list-style-type: none"> <li>Fascination of society with crime and criminality; Perception in society of increased violence</li> </ul>
<i>Role of Health Care System in Society</i> <ul style="list-style-type: none"> <li>Awareness of the health care role in response to violence</li> </ul>	<i>Role of Health Care System in Society</i> <ul style="list-style-type: none"> <li>Physicians -Too busy, no time, do not want to go to court</li> </ul>
<i>Expectations of Society</i> <ul style="list-style-type: none"> <li>Online education, Needed forensic skills, recognition of needed forensic nursing roles and specialty</li> </ul>	<i>Expectations of Society</i> <ul style="list-style-type: none"> <li>Resistance to online education</li> </ul>
<i>Image and Role of Nurses in Society</i> <ul style="list-style-type: none"> <li>Acceptance/trusted, High trust ratings in US and CA surveys; Increased acceptance &amp; need for forensic nursing roles; Court decisions based on nursing testimony.</li> </ul>	<i>Image and Role of Nurses in Society</i> <ul style="list-style-type: none"> <li>Historically negative concepts by society of forensic nursing, Physician role sanctioned by society without basis of forensic training</li> </ul>
<i>Forensic Nursing Education</i> <ul style="list-style-type: none"> <li>Acknowledgement &amp; need for forensic nursing education, Demand from nurses for more education, Nurses need forensic education for the job</li> </ul>	<i>Forensic Nursing Education</i> <ul style="list-style-type: none"> <li>Nursing shortage issue, Impact on specialty education requirements</li> </ul>
<i>Working in Multidisciplinary Roles</i> <ul style="list-style-type: none"> <li>Forensic Nursing has raised the profile &amp; image of forensic pathology</li> </ul>	<i>Working in Multidisciplinary Roles</i> <ul style="list-style-type: none"> <li>Physician role sanctioned by society without basis of forensic training</li> </ul>
<i>Employment</i> <ul style="list-style-type: none"> <li>Shortage of Nurses so high Nurse Employment Rate</li> </ul>	<i>Employment</i> <ul style="list-style-type: none"> <li>Employer not support graduate education because take away bedside nurse during shortage</li> </ul>

#### *Awareness in Health Care System--Positive*

- Socially, it's positive. At least over the years health professionals have become increasingly aware, that violence is a health issue generally. We've realized we need to have a better health care system response. (Q11-P12)

*Society Awareness of Violence --Positive*

- The fact that all of society has the growing awareness of and, and tolerance, or suspicion, or fright of the growing violence, and criminal activity, and terrorism, and whatever is going on, has heightened the awareness for all kind of professionals to be involved in forensic application. (Q11-P10)

*Social Trend --Positive*

- There is sort of a trend now that people want forensic knowledge. (Q11-P03)

*Society Need for Forensic Nursing Education--Positive*

- First of all there has been an acknowledgement of the critical need for Forensic nursing education, the state of the country, terrorism, unrest - the media focusing on that. The tragedy, both man-made tragedy, the natural disasters. (Q11-P03)

*Awareness among High school students--Positive*

- In the US, and my guess is that in Canada too we have high school students now who are, or high school biology chemistry teachers who are providing forensic type experiences in high school laboratories because of this interest so it's occurring beyond just the college and university level down into the high school and sometimes the middle school (Q11-P06).

*Social Impact by the Media--Positive*

- The media has had a real impact on society and what society expects. (Q11-P20)

*Social Acceptance of the nursing in society--Positive*

- Macleans did a survey across Canada that I just recently pulled...it was that nurses are the second or third most trusted...far above police officers, doctors, lawyers, you name it? And I think, I think, firefighters were the number one. (Q11-P09)
- I think society's acceptance of the nurse, and particularly that its the most trusted profession in the U.S., from a survey in the US. (Q11-P19)

*Social Image of Forensic Nursing--Positive*

- Than socially, for example news media articles, recognition by the media, forensic nurse examiners have all, brought a positive perspective to nurses who provide care for victims of domestic violence, and child abuse, sexual assault where previously that type of support wasn't there. (Q11-P08)

*Multidisciplinary Benefits to other disciplines--Positive*

- And this means that whatever we do in this forensic area...other components of a multidisciplinary team fair favorably. (Q11-P09)

### *Social Factors--Negative*

Social factors that negatively influenced the forensic nursing educational development were: the perception of increased violence in society, the public fascination with crime, the sanctioned role of physicians in society that certain roles were best performed by a physician without any expectation of training, and the limiting side of a social trend, that is the bandwagon effect. Examples of data extracts were:

#### *Societal Fascination--Negative*

- Fascination with crime and criminality. (Q11-P01)

#### *Societal Perception of Rising Crime--Negative*

- The roles of forensic programs...such as CSI have raised the interest of people into a rising perceptions even though it's not supported statistics, rising perception of community violence and unrest. (Q11-P02)

#### *Society Perception of Nursing--Negative*

- Where historically as you and I both have remarked in the past, [forensic nursing] had a very negative concept [in society]. (Q11-P08)

#### *Forensic Role given by Society to Physicians Without Training*

- But routinely Emergency Physicians, with no forensic training, are those primarily called upon, to do everyday sexual assault examinations and they have no forensic expertise. (Q11-P08)

#### *Qualifications--Negative*

- Most of the SANE programs in the US or Canada are not actually college accredited? (Q11-P12)

#### *Bandwagon Effect or Social Trend-- Negative*

- I do have a fear however, that some universities may be starting forensic programs because they're a popular topic. Yet I'm unclear whether the faculty that are being chosen to teach it truly know what they're teaching. (Q10-P16)

***Q11b. Media Factors***

Table 4.11b.

*Q11b. Media Factors--Positive and Negative*

<i>Media—Positive</i>	<i>Media--Negative</i>
<p><i>Entertainment Media</i></p> <ul style="list-style-type: none"> <li>• Awareness of society of forensic field &amp; Roles, Made forensic a household name, Media as information source for the public</li> </ul> <p><i>Public Information of High Profile Cases</i></p> <ul style="list-style-type: none"> <li>• Awareness &amp; Information for the public re forensic terms and issues</li> </ul> <p><i>Media Support of Professionals Recognition</i></p> <ul style="list-style-type: none"> <li>• News articles</li> </ul> <p><i>Media Advocate</i></p> <ul style="list-style-type: none"> <li>• Missing children advocate for the family</li> </ul> <p><i>Media Interest</i></p> <ul style="list-style-type: none"> <li>• Sparked, Created interest</li> </ul> <p><i>CSI Phenomena</i></p> <ul style="list-style-type: none"> <li>• Increased interest in role</li> </ul>	<p><i>Entertainment Media</i></p> <ul style="list-style-type: none"> <li>• Inaccurate portrayal of Forensic roles, nurses role absent or hidden, Romanticized /glamorized of forensic roles. Inaccurate portrayal of evidence</li> </ul> <p><i>Public Information of High Profile Cases</i></p> <ul style="list-style-type: none"> <li>• Trial in the media of high profile cases Sensationalism</li> </ul> <p><i>Media Support of Professionals Recognition</i></p> <ul style="list-style-type: none"> <li>• Nurse role Hidden, negative</li> </ul> <p><i>Media Advocate</i></p> <ul style="list-style-type: none"> <li>• Media uses the families to sell news, capitalizes on grief</li> </ul> <p><i>Media Interest</i></p> <ul style="list-style-type: none"> <li>• No favors for nurses</li> </ul> <p><i>CSI Effect</i></p> <ul style="list-style-type: none"> <li>• Unrealistic expectations, Less guilty verdict /Less prosecution</li> </ul>

*Media- -Positive Factor*

Positive media factors that influenced the forensic nursing educational development were: public education by the media of high profile cases, numerous forensic TV shows (e.g., CSI), media assistance in missing children campaigns, and increased interest in the forensic role due to attention in the popular media. Examples of data extracts were:

*Awareness--Entertainment Media--Positive*

- You couldn't talk about forensic nursing without the impact of the media on people's interest. (Q11-P07)
- I think that with media and technology, a wider population has become aware of the forensic world. (Q11-P03)

- Certainly television programs have influenced it. Forensic science has been brought into the home of almost every American, as well as internationally has highlighted it in a very positive sense [in society]. (Q11-P08)
- That of course was then followed by, a million T.V. shows of which CSI is probably the best known. (Q11-P16)

*Marketability--Positive*

- The media like CSI and Forensic files has made forensic highly marketable as opposed to truly a passion for forensic sciences more of, what's marketable. (Q9-P06)

*Popular Role Romantic & Glamorizing--Positive*

- After 9/11, all of these shows on television, that are based in the forensic sciences have made it kind of a romantic profession to be in. (Q11-P05)
- All the shows on TV like CSI that have been popularizing, and glamorizing the forensic area has got interest up. (Q11-P10)

*CSI Phenomenon--Positive*

- I have to tell you, like it or not it's CSI. You know there is what we call the CSI phenomenon. (Q11-P09)
- Well the CSI effect has certainly made everyone aware of what the forensic scientist does, but they've also made juries expect DNA evidence to prove everything, everywhere, all the time, and victims as well. So that's been a real mixed bag, as I'm sure many people have told you. (Q11-P20)

*High Profile Cases--Positive*

- High profile cases in the media have had a big influence: The OJ Simpson Case, the Elizabeth Smart case, the Lacey Pederson Case. Here in Canada the Pickton case in BC. (Q11-P09)

*Media Education of the Public--Positive*

- Public are being more aware, of, of the significance of certain things. Hard pressed to find somebody who would throw....clothes in an, in a garbage bin that may be evidence. The talk shows have been helpful in this regard. (Q11-P09)

*Media Advocate for Victims--Positive*

- In the missing children cases it seems that if the family is there for the media, then the media will use them. (Q11-P09) [The family use the media too because they, they want something done, they're desperate, and they feel they're not getting anywhere, or it's their last hope]

*Media--Negative Factor*

Media factors that negatively influenced the forensic nursing educational development were: the sensationalism of crime; the misrepresentation of forensic roles in

the media; the hidden role of the nurse in the media; and the exploitation of victims in grief to sell the story. Examples of data extracts were:

*Awareness--Awareness--Negative*

- The Media it's very entertaining, but it certainly hasn't helped us. (Q11-P07)

*High Profile Cases Sensationalism of violence & forensic cases--Negative*

- When students get caught up in the sensationalism of the setting, the crime or the patient (given his or her media status) (although as a teacher I know that some of this is to be expected). (Q8-P01)

*Media Support of Nurses Misunderstood--Negative*

- Unfortunately, the vast majority of these shows, pretty much have ignored, or not accurately portrayed the role of nurses in the field of forensic health care. (Q11-P16)

*Media/Technology--Negative*

- The media I think to some degree has hurt us a great deal, not so much nursing per se but law. When you take a suspect or an alleged criminal into a court of law now with a jury and you are trying to prove a guilt beyond a reasonable doubt, and they've just watched forty-seven (47) CSI programs that make it look like DNA analysis takes ten (10) seconds and everybody has a profile and everybody's finger print is online and you have all these computer technology experts that can just do all these simulation models and in real life that's not how it works. (Q11-P07)

***Q11c. Economic Factors***

Table 4.11c.

*Q11c. Economic Factors--Positive and Negative*

<i>Economic—Positive</i>	<i>Economic—Negative</i>
<i>Cost Effectiveness of Program</i> <ul style="list-style-type: none"> <li>• Gov't funding, gov't grants, undergraduate, Cost recovery due to popularity, high enrollment, SANE program self-sufficient</li> </ul>	<i>Cost Effectiveness of Program</i> <ul style="list-style-type: none"> <li>• Little graduate school funding or grants from gov't, Availability of Jobs, More research needed re cost effectiveness</li> </ul>
<i>Cost of Tuition</i> <ul style="list-style-type: none"> <li>• Tuition paid by employer</li> </ul>	<i>Cost of Tuition</i> <ul style="list-style-type: none"> <li>• Cost of tuition, Availability of Jobs</li> </ul>
<i>Role Compensation</i> <ul style="list-style-type: none"> <li>• Equal to other nurses</li> </ul>	<i>Role Compensation</i> <ul style="list-style-type: none"> <li>• Compensation inadequate, On call</li> </ul>
<i>Cost of Technology</i> <ul style="list-style-type: none"> <li>• Advanced Technology is better and faster</li> </ul>	<i>Cost of Technology</i> <ul style="list-style-type: none"> <li>• Cost to the tax payer, high profile only</li> </ul>



### *Economic Influences--Positive*

Positive economic factors that influenced the forensic nursing educational development were: governments have increased funding for needed programs, and the cost recovery of forensic educational programs due to the popularity of the course and resultant high enrollment. Examples of data extracts were:

#### *Cost Effectiveness of Educational Program/Role--Positive*

- One of the things that I've really focused on the last couple of years is and I think successfully is, putting the SANE program in a position where it supports itself and actually makes money for the hospital. (Q11-P20)

#### *Cost of Tuition to Nurses/Students--Positive*

- The institution or the hospital they come from is willing to pay the course tuition. That's a positive factor. (Q11-P05)

#### *Role Compensation to Nurses--Positive*

- And today, the most, progressive death investigation program in Houston, Texas, has done exactly what Dr. Butt, did in Alberta. I mean they're paid the equivalent salary in clinical and the majority of them are, Master's prepared and those that are not are working on their Master's degree. (Q11-P08)

#### *Job Economic Climate--Positive*

- Nursing is one of the few professions in which few people are without a job, so there's strong employment opportunities. So again there's a, some good to the economic climate as far as individuals coming back to graduate school because all of them are employed, and there is a need for individuals in nursing. (Q11-P07)

### *Economic Influences- -Negative*

Economic factors that negatively influenced the forensic nursing education and development were: the inadequate role compensation for nurses in some forensic roles (e.g., sexual assault nurse examiners and nurse as death investigators specifically); the high cost of advanced technology; the lack of program funding; and the minimal amount of research with regard to the cost effectiveness of the forensic role. Examples of data extracts were:

*Cost Effectiveness of Educational Program/Role--Negative*

- Always a cost to run this type of program. (Q11-P05)
- The economic influences are one of the biggest struggles right now with trying to get forensic nursing into the health care system. (Q11-P16)

*Cost of Tuition to Nurses/Students-- Negative*

- Cost of the tuition for the students. (Q11-P05)

*Role Compensation to Nurses--Negative*

- Nurses who were doing sexual assault examinations were not being paid comparison salary to nurses in the health care system. (Q11-P08)

*Economic –Money for Education--Negative*

- On the graduate level, because of the nursing shortage, nurse managers and other people actually dissuade individuals from going back to graduate school because that's going to take a bedside nurse. (Q11-P07)

*Cost of Technology--Negative*

- Now, granted, most communities do have the ability to do DNA analysis, but they take months, and months in order to get these kinds of results back, at a cost to the tax payers that is phenomenal. (Q11-P07)

***Q11d. Technology Factors***

Table 4.11d

*Q11d. Technology Factors--Positive and Negative*

<i>Technology—Positive</i>	<i>Technology—Negative</i>
<i>Advanced Science</i>	<i>Advanced Science</i>
<ul style="list-style-type: none"> <li>• Databases, helped those wrongfully accused, Easier, less invasive, more humane, comfortable for victim</li> </ul>	<ul style="list-style-type: none"> <li>• Jobs in large urban areas only, Complex, requires training and skill,</li> </ul>
<i>DNA</i>	<i>DNA</i>
<ul style="list-style-type: none"> <li>• DNA Analysis Saliva rather than blood</li> </ul>	<ul style="list-style-type: none"> <li>• Cost to the tax payer, Time for analysis</li> </ul>
<i>CSI Phenomenon/CSI Effect</i>	<i>CSI Phenomenon/CSI Effect</i>
<ul style="list-style-type: none"> <li>• CSI Phenomenon, Awareness, increased interest in the role</li> </ul>	<ul style="list-style-type: none"> <li>• CSI effect, difficult to convict without DNA evidence, Bar set high</li> </ul>
<i>Online Education (advanced technology)</i>	<i>Education (advanced technology)</i>
<ul style="list-style-type: none"> <li>• Serving rural and under-served areas, Benefits to students, Accessibility, Use experts from afar to write and teach, Information Access</li> </ul>	<ul style="list-style-type: none"> <li>• Face to face is better advocates, Some students esp. older learners struggle with technology of computers, Sort out the vast quantity of information</li> </ul>
<i>Practice (advanced technology)</i>	<i>Practice (advanced technology)</i>
<ul style="list-style-type: none"> <li>• Technical tools for Sexual assault Colposcope as standard of care, chemical markers like Toluidine Blue, Camera</li> </ul>	<ul style="list-style-type: none"> <li>• Does technology benefit the client? Are conviction rates any different? Skill and training required to use Technology</li> </ul>

### *Technology Influences--Positive*

Positive technology factors that influenced the forensic nursing educational development were: the numerous advancements made in technology such as DNA research and DNA databases that have increased the importance of evidence and provided the truth for the wrongly accused; and online education has increased the accessibility of information globally and has changed the face of education significantly.

Examples of data extracts were:

#### *DNA Technology--Positive*

- The technological factors have been certainly DNA science. (Q11-P11)
- The ability to do DNA analysis even on trace amounts of evidence has really I think improved the role of the Sexual Assault Nurse Examiner that we only need a miniscule amount of evidence collected in order to get DNA matches. So I think the role of, especially in the area of sexual assault, SANE to continue with our evidence collection knowing that the labs are getting better and better and better at utilizing what we've collected. (Q11-P16)

#### *DNA CSI Effect Wrongly accused DNA-- Positive*

- DNA has had the ability to help the wrongfully accused, many cases in both countries. (Q11-P09)

#### *CSI Phenomenon--Positive*

- The CSI Phenomenon has provided a window into the world of forensic science. It may not be an accurate portrayal but it is a portrayal. (Q11-P09)

#### *Online Courses/Program due to Advanced Technology--Positive*

- Online courses allow access to resources and accessibility. (Q11-P01)
- Online Program - one of the major focuses that we have is on serving rural and under-served areas, our program is totally online, so we have military people, who are in Germany, and Iraq.(Q11-P17)

#### *Technology Online educational technology--Positive*

- Sexual assault technology colposcope/camera, advanced, technology. (Q11-P08)

### *Technology Influences--Negative*

Technology factors that negatively influenced the forensic nursing educational development were: the person in trauma sometimes may be lost in the attention of the

advanced technology; the CSI phenomenon/effect has made prosecution difficult without DNA evidence; and some practitioners struggle with new technology skills needed to keep current in the field. Examples of data extracts were:

*Availability of Jobs—Negative*

- I would say from a technological perspective, again because forensic nursing is truly so different from other types of nursing practice, that you would have to live in a very, very large urban area to justify. (Q11-P06)

*Online Education--Negatives of Advanced Technology-- Negative*

- Getting over the hurdle that some of these folks who have been practitioners have, that the only way you can really deliver good education is face to face in the classroom. Some faculty were very resistant to teaching online. (Q13-P06)

*Cost of Technology-- Negative*

- These TV shows, although are not necessarily inaccurate, they give the impression that this is common practice. When indeed, that degree of attention to detail, is typically just for high profile cases. Because of the money that it costs and the number of personnel needed, it is just not realistic in most communities. Most communities do not have that tax base, to support that kind of investigation. (Q11-P07)

***Q11e. Political Factors***

Table 5.11e.

*Q11e. Political Factors--Positive and Negative*

<i>Political—Positive</i>	<i>Political—Negative</i>
<i>Legislative &amp; Policy Change</i> <ul style="list-style-type: none"> <li>• Forensic nurses pushed for legislative changes; court decision * nursing testifying</li> </ul>	<i>Legislative &amp; Policy Change</i> <ul style="list-style-type: none"> <li>• Uphill battle</li> </ul>
<i>Emerging Social Priorities/ Societal Need</i> <ul style="list-style-type: none"> <li>• Forensic nursing expanded roles and educational development</li> </ul>	<i>Emerging Social Priorities/ Societal Need</i> <ul style="list-style-type: none"> <li>• Societal understanding of traditional roles, Physician Role Sanctioned</li> </ul>
<i>Specialty Status</i> <ul style="list-style-type: none"> <li>• ANA recognition as a specialty</li> </ul>	<i>Specialty Status</i> <ul style="list-style-type: none"> <li>• Generalist approaches, Specialist care</li> </ul>

### *Political Influences--Positive*

Positive political factors that influenced the forensic nursing educational development were: legislation and policy changes that have aided the role expansion of the nurse; the granting of specialty status of forensic nursing in 1995 by the American Nurses Association (ANA, 1995); and emerging social priorities. Examples of data extracts were:

#### *Policy--Positive*

- The American Nurses Association, in 1995 when they acknowledged forensic nursing as a specialty not a sub-specialty. That gave some policy political justification to this as a specialty. (Q9-P16)
- Forensic nursing had many other social, legislative, court decisions that were occurring that, that pushed it to the forefront. (Q11-P19)

#### *Societal Need--Positive*

- The key is the nursing educators have to recognize that this specialty, was one that was needed, and they didn't have an infrastructure to address it. (Q11-P19)
- Seems like we fall into things because people need us to do them, and I think that's kind of what's has happened here in forensic nursing too. (Q2-P10)

#### *Emerging Social/Political Priorities--Positive*

- You can never leave politics and emerging social priorities out of where we seem to find ourselves. (Q2-P10)
- And then finally the American Nurses Association in 1995 when they acknowledged forensic nursing as a specialty, that gave some political justification to this as a specialty. (Q9-P16)

### *Political Influences--Negative*

Political factors that negatively influenced forensic nursing educational development were: generalist versus specialist education; the societal understanding of traditional professional roles, and the chronic resistance of change. Examples of data extracts were:

*Specialization-- Negative*

- And I would rather say to people, we can all provide care to a sexual assault victim. Maybe it's in different degrees, but I worry around specialization on the issue. Particularly because, people will say. Oh let's send them to the big city because they have the specialists. And it's like you don't have to be a specialist to provide good care. (Q9-P12)

*Constructed Connotations*

It could be said that a bandwagon effect occurred in the rise in popularity of the forensic professions, which was fueled by media attention to the word *forensic* (meaning forensic science or forensic medicine). Media exposure brought a fascination with forensic science, and with all aspects of working with victims and offenders. Subsequently, forensic pathology also became viewed differently than it had been in the past.

Multiple factors influenced the development of forensic nursing educational development both positively and negatively. Social, media, economic, technology, and political factors had a mixed influence on the development of forensic nursing education. *Both/and* was noted to be a constructivist connotation throughout, that were manifested by both positive and negative as constructed connotations. The responses generated from the "Factors Influencing" question contributed to the main *Positive and Negative* themes of this study (See Chapter 5 Findings – Factors Influencing).

❖ Positive and Negative Factors Influencing

***Q12. Reasons Why Educational Development Did Not Occur Sooner***

Question 12 asked why formalized forensic nursing educational courses/programs were not developed earlier for college and university delivery. In responding to this question, participants also gave the antithesis, or the facilitating factors as to why the

course/program were developed. Throughout many of the telephone interviews, when responding to other questions, participants also commented on the historical reasons why forensic nursing came about. Therefore, some of those responses will also be included in this subsection. I divided the data into the following categories and subcategories:

faculty/forensic nurse educator, curriculum structure/forensic content, public awareness/nursing role, market demand/need, administration/university/nursing department, and other disciplines/physicians (See Table 4.12. Question 12).

*Table 4.12.*

*Q12. Reasons Courses Developed and Why Not Sooner*

<i>Reasons Courses Developed? Facilitators Theme</i>	<i>Reasons Courses NOT Developed sooner? Barriers Theme</i>
<i>Faculty - Nurse Educator</i> <ul style="list-style-type: none"> <li>• Individual nurse</li> <li>• Interest/Drive /passion/ mission</li> </ul>	<i>Faculty - Nurse Educator</i> <ul style="list-style-type: none"> <li>• Lack of Experts in the field to develop the courses/programs and teach</li> </ul>
<i>Curriculum Structure - Forensic Content</i> <ul style="list-style-type: none"> <li>• Electives available</li> <li>• Certificate</li> <li>• Specialty courses at graduate level programs</li> </ul>	<i>Curriculum Structure - Forensic Content</i> <ul style="list-style-type: none"> <li>• No electives</li> <li>• No room in curriculum</li> <li>• Considered specialized</li> <li>• Curriculum competition</li> </ul>
<i>Role Awareness</i> <ul style="list-style-type: none"> <li>• Public Awareness</li> <li>• Social Need/ Demands</li> <li>• Media Attention</li> <li>• Needed Role</li> </ul>	<i>Role Awareness</i> <ul style="list-style-type: none"> <li>• Unaware of Role</li> <li>• Not the Right Time</li> <li>• Not seen as Essential/Needed</li> </ul>
<i>Market Demand</i> <ul style="list-style-type: none"> <li>• Jobs available/created</li> </ul>	<i>Market Demand</i> <ul style="list-style-type: none"> <li>• Jobs not available</li> </ul>
<i>Administration</i> <ul style="list-style-type: none"> <li>• Supportive, visionary,</li> <li>• Understanding the role</li> </ul>	<i>Administration</i> <ul style="list-style-type: none"> <li>• Not understood as a nursing role, resistance, skepticism</li> </ul>
<i>Other Disciplines</i> <ul style="list-style-type: none"> <li>• Collaboration</li> </ul>	<i>Other Disciplines</i> <ul style="list-style-type: none"> <li>• Resistance</li> </ul>

### *Reasons Why Forensic Nursing Courses Developed*

Reasons why forensic nursing courses/programs were developed were: there was a significant person that was the driver, who followed her/his passion and mission; curriculum structures that allowed for elective options were facilitative; full certificate forensic nursing programs and specialty courses/programs were inserted at the graduate level; media attention increased public awareness of the field; there was a need for the role that resulted in market demand and job creation; administrators who understood the role and were supportive and visionary to facilitate the process; and collaborations with other disciplines that created a broad perspective. Examples of data extracts were:

#### *Faculty--Forensic Nurse Educator*

- The fact that I did this was the result of the increasing concern that I had regarding the need to do more for victims of violence, law enforcement relationships and perpetrator dynamics. (Q1-P03)
- You know so many times, a program is developed because of an interest by a particular faculty member. (Q13-P07)

#### *Curriculum--Forensic Content*

- We recently made several changes to our curriculum, now we are able to offer more electives for specialty education, before when all the courses were core courses - or general courses there was not a lot of room over and above the core courses. We revised some of the core credits by decreasing the core courses and increasing the electives. Now the student nurses have more of a choice. (Q12-P13)

#### *Construct/Create*

- We have a slowly growing number of universities and colleges who are beginning to create forensic nursing programs especially, advanced practice or master's level. (Q10-P16)

#### *Awareness of Role - Public and Nurses*

- With the rising media awareness, the rising...violence. I believe that there's more support for the creation of positions, and the role of nurses (#12-P02). In there, as well as the role of nurse practitioners developing. There is I believe a growing awareness that nurses can have an independent and progressive role in intervening in these areas. (Q12-P02)



*Market – Demand/Need*

- So many prospective students were calling the school saying do you have something called a forensic nursing program that the admissions people first of all used to say- what is forensic nursing? And now they're trying to figure out how they can get somebody on faculty, even part time, who can teach forensic nursing. (Q12-P16)

*Administrators – University/Nursing*

- Supportive, visionary, once they understood the role, they supported it. (Q12-P05)

*Why Forensic Nursing Courses Were Not Developed Sooner*

Reasons why forensic nursing courses/programs were not developed sooner were: lack of experts in the field to develop the courses/programs and teach them; no elective options, no room in the undergraduate curriculum or there was curriculum competition; forensic was considered specialized knowledge or as knowledge from other disciplines; the public and nurses themselves were not aware of the role or did not feel it was the time for it; market demand was not there and related jobs were not available; administrators were not interested, did not understand the role, and were skeptical; and resistance appeared from other disciplines, especially physicians.

Examples of data extracts were:

*Faculty--Forensic Nurse Educator (Lack of experts in the field)*

- One of the reasons why colleges did not until recently have formalized forensic nursing classes because there are only a handful of us truly, in North America who have a master's degree or higher and would be eligible to teach at the college and university level. (Q12-P16)

*Curriculum--No room for elective options*

- Our nursing curricula, where we just don't tend to have room for those types of specialized courses. (Q12-P01)

*Awareness of Role--Public and by Nurses (Unaware, Not the time)*

- Oh I think they couldn't have, for one thing we didn't even understand the concept of forensic nursing. So I would suggest that they started sooner than many specialties. (Q12-P19)

- Educators were not on board as soon as they could have been. (Q12-P19)

*Other Disciplines--Physicians Resistance*

- Because first of all it was a physician dominated area. Some physicians said “that’s not a nursing responsibility, you can’t do that”. Nurses should not be doing death scene investigation, or much less rape examinations said - this is strictly within the scope of medicine. (Q12-P08)
- And there’s a lot of folks who still look at it and say, this is not nursing. (Q12-P10)

*Market--Demand/Need (Jobs not available)*

- I don’t think there were the jobs for them. I think in some ways the job market drives our nursing education. (Q12-P20)

*Administration--University/Nursing*

- There’s still a lot of people that don’t value it, don’t see as something that is sustainable. (Q12-P10)

*Constructed Connotations*

The main reason for the development of forensic nursing courses/programs may be the mission and passion of individual nurses. The lack of resources or funding was not specifically identified as a reason why courses did not start sooner, because many of the educators developed courses with very little compensation and many were not on faculty.

Multiple factors contributed to why forensic nursing courses were developed and why they were not developed sooner. Multiple factors or multiple perspectives are constructed connotations. The responses generated from “Why Forensic Courses Developed and Why Not Sooner” question contributed to the main *Factors Influencing* theme of this study (See Chapter 5, Findings – Influencing Factors).

❖ Influencing Factors - History

### Q13. Sustainability Factors of Forensic Nursing Courses/Programs

In Question Thirteen (the final question), the participant's were asked their perception with regard to reasons why forensic nursing course/programs were sustained. In responding to this question they also gave reasons why some forensic nursing course/programs were not sustained. The data was divided into the following categories: faculty, administration, resources, and students. (See Table 5.13. Question 13)

Table 4.13.

#### *Q13. Sustainability Factors--Positive and Negative*

<i>Positive facilitating influences SUSTAINED</i>	<i>Negative impeding influences Not SUSTAINED</i>
<i>Faculty - Availability of Specialized Expert</i> <ul style="list-style-type: none"> <li>• Key Driver (passion, mission), Faculty is solid, Qualified, Sustained by growing their own graduate for future faculty</li> </ul>	<i>Faculty - Availability of Specialized Expert</i> <ul style="list-style-type: none"> <li>• Faculty left, Faculty recruited elsewhere, Faculty retired or ill, Expertise left with them, Difficult to replace, Few qualified to teach this specialty</li> </ul>
<i>Administration</i> <ul style="list-style-type: none"> <li>• Supportive</li> </ul>	<i>Administration</i> <ul style="list-style-type: none"> <li>• Non supporting</li> </ul>
<i>Resources - Funding – Online</i> <ul style="list-style-type: none"> <li>• Invested in online, Accessibility for students</li> </ul>	<i>Resources - Funding - Online</i> <ul style="list-style-type: none"> <li>• Lack of Resources, Not committed to invest in online</li> </ul>
<i>Students – Enrollment</i> <ul style="list-style-type: none"> <li>• Location, Access to Students - Online providing access for students</li> </ul>	<i>Students – Enrollment</i> <ul style="list-style-type: none"> <li>• n/a</li> </ul>

This question was not part of my original guideline of questions; however it was added it at the request of one of the first participants interviewed, and it was subsequently added to the list and asked of all the remaining responders. The data extract alluding to the sustainability question was:

- And the one question you didn't ask that you might want to ask and I'll answer it for you because I was wondering if you would ask it is: The original programs, do they still exist, have they expanded, or have they died? (Q1-P11)

### *Sustainability Factors--Positive*

Reasons for the sustainability of forensic nursing courses/programs were: a key driver who wrote and taught the courses, who also was that significant person with a mission and passion for forensic nursing; support from administration; the needed resources (e.g., online mode of delivery allowed for more accessibility of students and faculty); qualified faculty with forensic nursing expertise; and partnerships and/or affiliations with other disciplines, community, or government systems. Examples of data extracts were:

#### *Faculty*

- I think the ones that have survived, are the ones where the particular faculty has been solid. (Q13-P07)
- The main reason why there have been sustained would be the people teaching it. (Q13-P15)

#### *Resources*

- I think it's resources. I really think you know - who is available, because it's expensive...finding these specialized people who can teach (#13-P07) is challenging. (Q13-P07)
- I can only speak the why the SANE/SART programs haven't been sustained: number one is funding, number two is keeping the staff. The programs made money, they would be able to pay the staff better, then they'd be able to keep the staff. (Q13-P20)

#### *Students - Enrollment*

- Our location, we're very close to a high concentration of health care facilities and schools of nursing. We have in terms of numbers, and we see interest. (Q13-P06)

#### *Online Education - Accessibility to students*

- But then the other piece is that, we were really quite aggressive in pursuing the online education. I do think once they invest in online that does help with the commitment. (Q13-P06)

- University of XX is alive and well and growing very, very fast because of their online stuff, whereas another University is dabbling in a few electives, but growing very, very slow, but is still sustained. (Q13-P11)

*Broad Focus of Forensic*

- Every sub-specialty in forensic nursing has always known, that broad concept of all the nurses practicing in a forensic arena, that we belong together, and what gave me that idea of course was the American Academy of Forensic Science. (Q13-P08)

*Lack of Sustainability--Negative*

Reasons for the lack of sustainability of forensic nursing courses/programs were: lack of qualified faculty (one person programs); lack of administrative support; lack of resources (e.g., low funding, or lack of qualified faculty); and low compensation for SANE trainers and examiners. Examples of data extracts were:

*Faculty--Loss of / Lack of Specialized Faculty with Expertise*

- We require for tenure track that you have a Ph.D. And so we're having to kind of having to grow our own so I struggle every semester finding qualified individuals and when I say qualified, have that forensic knowledge base as well as technical a expertise to teach online. (Q13-P06)
- A couple of programs at universities I know of died because of lack of funding, and lack of faculty. There's got to be a key driver. Somebody who's willing to sort of be the martyr of the program. (Q13-P11)
- But a lot of the issues, why they die is that they're one person programs at this point. We don't have enough people in reserve, who have the ability and interest to teach this...around the continent. (Q13-P16)

*Online Education*

- I don't think the investment in online courses helps the sustainability. Sustain it no. (Q13-P15)
- Many faculty have a difficult time getting over the hurdle that some of these folks who have been practitioners have, that the only way you can really deliver good education is face to face in the classroom. (Q13-P06)

*Resources - Lack of*

- It's resources, who is available, because it's expensive...finding theses specialized people who can teach is challenging. (Q13-P07)
- Some forensic nursing programs SANE programs pay terribly; and that's an issue and when there's a shortage, it's more of an issue. (Q13-P20)

### *Constructed Connotations*

The question of sustainability factors revealed significant responses that would evolve into some of the main themes of the study. It was evident from the data that there were multiple reasons for sustainability. In the early years of forensic nursing education development, it became evident that both the expertise of clinicians and the support of administrators were needed to maintain programs that were new and not yet recognized as future mainstay programs. The responses generated from the “Sustainability” question contributed to the main *Factors Influencing* themes of this study (See Chapter 5 Findings--Factors Influencing).

#### ❖ Positive and Negative Factors Influencing

##### *Summary Analysis of Phase II--Qualitative (Telephone) Interview*

In the first five questions in the qualitative interview, the different components of the knowledge of forensic nursing were examined: definition, conceptualization, philosophical base, and unique knowledge. Questions 1-5 built on each other. All were a bit different and I found that the educator’s response to one question often overlapped and clarified their thoughts on a previous question. Therefore, when I sorted the data extracts, I placed some with previous or later questions that they also were applicable to. The responses to the first five questions became some of the main *Knowledge Themes* in Chapter Five.

In Question 6, the participants were asked how their knowledge was gained in order to develop the forensic educational courses/programs; their responses were

correlated with questions S3, S6m and S7 in the email survey, which asked about the educator's clinical and educational experience.

In Question 7, I asked for the titles of their educational modules and correlated their responses with the email survey question S8 and S19. Because *Concepts to Include* in educational programs was elicited in responses throughout the dataset, the findings were included in Chapter Five as a *Taxonomy of Knowledge Concepts to Include*.

Finally, I analyzed the responses to Questions 8-13 of the qualitative interview, using Positive and Negative Factors of satisfaction, social, media, economic, technology, political and sustainability. Although Questions 8-13 were six different questions, I was able to categorize them all alike under the main theme of Positive and Negative factors, because all were related to factors that facilitated or impeded the knowledge development of forensic nursing education. The evolvement of the main themes can be identified in the tables summarizing the analysis of each question in Chapter Four (See Appendix D7. Phase II—Summary of Qualitative Responses).

### *Thematic Analysis Summary*

A thematic analysis was conducted on the qualitative data. The thematic analysis was based on Braun and Clarke's (2006) five phases of data analysis. Transcripts were read and reread for an overview understanding of the body of material. The interview databases were coded and condensed into categories. Data collection, coding and analysis were done concurrently. Analysis was done in the process of comparing and contrasting the results of this coding. Similar categories for each question took the form of what is, is

not, is a combination of, is influenced by, or depends on. The antithesis (was/was not, or positive/negative) often became the subcategories.

Theoretical notes were generated in the form of tables, databases, typologies, and taxonomies. These notes were interpretative, giving a conceptual framework to the codes. In this study, data extracts or representative quotations from the interview data were used to illustrate the analysis. The overall themes became the different divisions of knowledge of forensic nursing that were evident in the data: description or delineation of knowledge, needed knowledge, unique knowledge, differential knowledge, dual knowledge, and definition of knowledge. A thematic analysis of interview data interpreted from a constructivist approach was an appropriate method for generating explanations of phenomena that are directly relevant for this focus of study.

#### *Key Finding of Qualitative Interview*

Although the educational development of the forensic nursing specialty had been influenced by many facilitating and impeding factors, such as societal need, media attention, public awareness, and technological advances – it was above all, the societal need for a nursing medico-legal role that was the main reason for forensic nursing and forensic nursing education coming about.

- Forensic nursing evolved from the *need* to increase the care to victims and perpetrators, some from *societal need* and some from *our own need* to improve the services. (Q11-P10)

#### Summary of Chapter Four

The purpose Chapter Four was to present the analysis of Phase I, the email survey, and Phase II, the qualitative interview. The main responses to each question



asked of the participants, I cited here in this chapter. An analysis of the data from both Phases together began to answer the two main research questions of this study: What is forensic nursing knowledge as a specialty area of study, and what factors influenced forensic nursing educational development. The most significant Themes identified in this chapter were all placed in Chapter Five, Findings, that I next discuss.

## CHAPTER FIVE

## FINDINGS--KNOWLEDGE THEMES

In Chapter Five, I provided the main findings or themes of the study that were identified after an analysis of both the descriptive statistics and the qualitative interview in Chapter Four. Because the purpose of the study was to explore forensic nursing knowledge as a specialty area of study and factors influencing its educational development, I divided the themes into *knowledge* themes and *influencing factors* themes (See Table 5.00. Overview of Themes and Findings).

Table 5.00.

*Overview of Themes and Findings*

<i>Knowledge Themes</i>	<i>Factors Influencing Themes</i>
Knowledge Delineation (Typologies)	Positive and Negative Influencing Factors
Knowledge Needed and Concepts to Include	Historical Influencing Factors
Knowledge Differentiated	Significant Influencing Person
Knowledge Dual	
Knowledge Defined	

*Findings*

Forensic Nursing Concepts to Include  
 Forensic Nursing Definition (Constructed)  
 Forensic Nursing Practice Model  
 Forensic Nursing Meta Theory

I explained the relevance of each theme to this study and cited data extracts to provide evidence for the theme. I compared and contrasted some of the extracts from the data to the literature in order to provide validation for the findings. Because my worldview or paradigm of the study was a constructivist approach, I connected each theme to the principles of constructivism, where multiple realities exist. I placed my constructed connotations at the end of each theme indicating the interpretations I made from the data and the relevant literature.

- ❖ This bullet throughout the chapter signified constructed knowledge or a constructed definition.

#### Theme 5.10 Knowledge Delineated: Typologies

The delineation of forensic nursing knowledge was defined in this study as descriptions or descriptors of knowledge. The typologies were unique descriptors relevant to this *Forensic Nursing Education* study; although not the substantive part of the study, their purpose had relevance for the identification, and description of this specialty area. A descriptor or typology is the study or systematic classification of types. As a result of the data analysis, I identified many typologies and labeled them A-S. Typologies A-G were adjectives that were commonly found in the data identified as prefixes, and typologies H-S were the main forensic concepts found in the data. All typologies served to delineate or describe the forensic nursing specialty (See Table 5.10. Theme: Knowledge Delineated: Typologies) for an overview of the Typologies.

Table 5.10

*Theme: Knowledge Delineated: Typologies*

<i>Prefix Sub Themes</i>
5.1A. Typology: Forensic Prefix (adjective) n=92
5.1B. Typology: Forensics (noun) n=7/16
5.1C. Typology: Unique Prefix n=11
5.1D. Typology: Law/Legal Prefix n=4 +8
5.1E. Typology: Law/Legal Relationship n=17
5.1F. Typology: Specialty Prefix n=8
5.1G. Typology: Emerging/Evolving Prefix n=3
<i>Forensic Sub Themes</i>
5.1H. Typology: Forensic Populations n=21
5.1I. Typology: Forensic Systems/Services n=9+7
5.1J. Typology: Forensic Focus n=6
5.1K. Typology: Forensic Care n=5
5.1L. Typology: Forensic Roles n=22
5.1M. Typology: Forensic Subspecialties n=11
5.1N. Typology: Forensic Disciplines
5.1O. Typology: Forensic Multidisciplinary
5.1P. Typology: Forensic Models & Frameworks
5.1Q. Typology: Forensic Nursing Process Paradigm (Pentalogy)
5.1R. Typology: Forensic Nursing Paradigm (Tetralogy)
5.1S. Typology: Forensic Meta Theory

*Typology 5.1A. Forensic Prefix*

From the Database of Key Words (Appendix E4), it was apparent that the word *forensic* was used frequently as an adjective in front of numerous words. In question 1, “What is forensic nursing?” The forensic prefix was used in front of 30 different words and this tabulation carried on for all 13 questions. A table was compiled of 92 words (See Table 5.1A. Typology: Forensic Prefix).

Table 5.1A

*Typology: Forensic Prefix (92)**Forensic as an Adjective to Describe 92 Concepts*


---

Forensic application	forensic knowledge	forensic principles
forensic area	forensic lab	forensic problems
forensic assessment	forensic labels	forensic program
forensic behavioral sciences	forensic lens	forensic psychiatric assessment
forensic care	forensic medicine	forensic psychiatric nursing
forensic careers	forensic mental health	forensic psychiatry
forensic cases	forensic mental health nursing	forensic psychiatry residency
forensic chemistry	forensic model	forensic psychiatrist character
forensic concepts	forensic needs	forensic psychologist
forensic conferences	forensic nurse	forensic psychology
forensic considerations	forensic nurse educator(s)	forensic research
forensic course	forensic nurse examiner(s)	forensic roles
forensic disciplines	<b>forensic nursing</b>	forensic science
forensic education	<b>forensic nursing education</b>	forensic scientists
forensic epidemiology	forensic nursing education program	forensic services
forensic evidence	forensic nursing generalist program	forensic settings
forensic examiners	forensic nursing graduate program	forensic situation
forensic experience	forensic nursing masters program	forensic skills
forensic expertise	forensic nursing practice	forensic sociology
forensic technicians	forensic nursing role	forensic specialty
forensic facilities	forensic nursing studies	forensic studies
forensic field	forensic nursing tract	forensic systems
forensic files	forensic organizations	forensic teams
forensic focus	forensic pathology	forensic theories
forensic framework	forensic pathology residency	forensic tools
forensic health care	forensic philosophy	forensic toxicology
forensic health sciences	forensic piece	forensic tract
forensic health studies	forensic place	forensically trained
forensic history	forensic point of view	forensic training
forensic investigators	forensic populations	forensic type experiences
forensic issues	forensic practice	
Total = 92		

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*Literature Comparisons to Forensic Prefix Typology*

A social influence began in the 1980s when the term *forensic* became increasingly popular. Many groups of professionals began to prefix their jobs with the labels of forensic (i.e., forensic psychiatry, forensic psychology, forensic social workers). The

prefix *forensic* represented the health care and law interface that best met the needs of a global society where threats of increasing violence were prominent (Mason, 2000).

The forensic focus became a popular focus for numerous TV shows beginning in the 1990s and continuing today. Examples of data extracts from this study were:

- I always approach them through my own forensic lens. (Q6-P01)
- There are so many television shows now that have a forensic focus, and more and more there's even a forensic psychiatrist character. (Q11-P06)

#### *Constructed Connotations of Forensic Prefix Typology*

In the entire dataset, the term *forensic* was used as an adjective or prefix for 92 different words. It became evident that the forensic prefix or adjective was put in front of almost every term to do with this specialty area as a qualifier, or an added descriptor so that each concept was identified as *forensic*.

#### *Typology 5.1B. Forensics (noun)*

The word *forensics* was also noted in the dataset and used by seven, n=7/16 of the participants. Some of the forensic nurse educators who participated in this study and developed some of the more recent courses used the term *forensics* as a noun freely without consideration of whether the use of the word was proper (See Table 5.1B. Typology: Forensics).

#### *Literature Comparisons to Forensics (noun) Typology*

The literature review explored the term *forensics*. Although *forensic* has been used for years as an adjective, and the term *forensics* has recently been used as a noun.

Table 5.1B.

Typology: *Forensics* (noun)

*Forensics Used as a Noun to Describe a Specialty or Area of Practice n = 7/16*

<i>Data Extracts</i>	<i>Literature Comparisons</i>
<ul style="list-style-type: none"> <li>• forensics. (Q6-P01)</li> <li>• forensics. (Q12-P05)</li> <li>• forensics. (Q6-P06)</li> <li>• forensics. (Q1-P07)</li> <li>• forensics. (Q12-P12)</li> <li>• forensics. (Q11-P16)</li> <li>• forensics. (Q8-P17)</li> </ul>	<ul style="list-style-type: none"> <li>• More interest in forensics (Naiman, 2006).</li> <li>• Forensics is a much bigger umbrella (Naiman, 2006).</li> <li>• <i>Quincy</i> coined the word <i>forensics</i> (Kent-Wilkinson, 1999b).</li> <li>• Forensic science often shortened to forensics (Wikipedia, 2007d).</li> </ul>

*Forensics*. The 1980s-1990s saw the construction of a new word *forensics* as a noun. *Forensics* was given attention from the media, then accepted into society and postmodern culture. Originally, it was only meant to be a shortened word for *forensic science*. Over time, the slang term of *forensics* seems to have eased its way into the language of postmodern culture. A few examples present in the data and used by some of the educators in this study were:

- All nurses need to have some knowledge about *forensics* in general and know a little bit more about the chain of custody and safe collection of evidence, or correct collection of evidence preserving it, but I think that the specialization of *forensic nursing* is its own body of knowledge. (Q12-P05)
- Nursing and law is *forensics*. So that includes all civil and criminal components as well as public policy, licensure, anything. Anything where the law intersects with nursing practice I consider *forensics*. (Q1-P07)
- I try to apply that coursework or develop the papers that I had to write within that course, in relation to my experience in *forensics*. (Q6-P01)
- And I also had myself done course work in *forensics* including forensic sciences so in that sense it came from personal experience, having been a student myself studying these. (Q6-P06)

When the popular television show *Quincy* coined the word *forensics*, the public adopted the word as if it was a legitimate discipline. However, some professionals in the

field felt the word was misused for the politically correct term for *forensic science*. Over the years there has been a dispute about the new term *forensics*. The question was whether or not *forensics* was a proper word used by itself as a noun, or misunderstood for the politically correct term *forensic* which is an adjective. Language specialists would say that the term *forensic* is an adjective so therefore should be used with a noun (i.e., forensic nursing, forensic crime scene, or forensic knowledge (Kent-Wilkinson, 1999b). The difference between *forensic* and *forensics* was explained by one participant in the following extract:

- A specialty in nursing is *forensic* [nursing], NOT a nursing specialty in *forensics* [short for forensic science]. (Q2-P08)

#### *Constructed Connotations of Forensics (noun) Typology*

Language and identity are important, and the adjectives used to construct a new specialty say much about professionals and their role in society. There was confusion when the adjective *forensic* suddenly become the noun *forensics* and become viewed as if it was a specialty of its own. However, *forensics* has no professional base. *Forensics* is not a stand-alone profession with a regulatory professional licensure.

Almost half of the participants  $n = 7/16$ , used the term *forensics* in their responses. But does *forensics* represent new knowledge? Is it an emerging specialty or discipline? Is the broad use of the word, *forensics* why high school students have a difficult time understanding that *forensics* is not the discipline. They often do not understand that there is a need to study in an established discipline at the undergraduate level, and that *forensic* or *forensics* are only focus areas but not the discipline itself.



In constructing a definition of forensic nursing, there is strong indication, both from the data and from the literature reviewed that *forensic* is the type of specialty and *nursing* is the discipline.

- ❖ A specialty in nursing is *forensic*, NOT a nursing specialty in *forensics*.

### *Typology 5.1C: Unique Prefix*

In responding to questions 1-13, *unique* as a prefix was often used similar to using the prefix or adjective meaning different, or forensic, or special (See Table 5.1C.

Typology: Unique Prefix).

Table 5.1C.

### *Typology: Unique Prefix*

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(11) *Unique used as an adjective in front of a noun (used in place of the prefix forensic)*

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#### *Data Extracts*

- unique affiliation. (Q2-P01)
- unique attributes. (Q2-P01)
- unique being. (Q12-P19)
- unique circumstance. (Q2-P01)
- unique discipline. (Q8-P06)
- unique knowledge. (Q5-P01)
- unique questions. (Q6-P01)
- unique problems. (Q2-P01)
- unique skills. (Q12-P19)
- unique specialty. (Q1-P01)
- unique tasks. (Q5-P01)

#### *Literature Comparisons*

- unique client population (Doyle, 1999).
  - unique paradoxical roles (Gudgeon, 2004).
  - unique specialty (Hammer, 2000).
  - unique social system (Doyle, 1999).
  - unique contribution (Baxter, 2002).
  - unique requirements and responsibilities (Gudgeon, 2004).
  - unique body of knowledge (Mason & Carton, 2002).
- 

### *Literature Comparisons to Unique Prefix Typology*

The literature often uses the prefix *unique* to describe the forensic specialty.

*Unique* is often used to describe specific forensic concepts, populations, and systems.

*Unique specialty.* Until the IAFN recently designated forensic nursing as a unique specialty, nurses had practiced forensic nursing for many years without formal

recognition of the domain as a sub-discipline for specialized study (Hammer, 2000). One example from the data was:

- Is forensic nursing a *unique* specialty area or is it nursing applied to a specialty population or a special environment. (Q1-P01)

*Unique forensic systems and services.* Forensic correctional and psychiatric services, especially are often referred to in the literature as *unique*. “Prison is a unique social system, where inmates live unwillingly and resentfully in a highly structured and regulated environment. Privacy is non-existent, surveillance is perpetual” (Doyle, 1999, p. 31).

*Unique populations.* “Correctional psychiatric mental health [CPMH] nurses deliver care to a unique and challenging client population” (Doyle, 1999, p. 34). Within secure psychiatric settings, they must provide care for and maintain custody of these patients, a paradoxical role that makes this type of nursing unique (Gudgeon, 2004). One example from the data was:

- Forensic nursing is *unique* because it serves the population of victims of violence, and perpetrators in a way that they haven’t been served before. (Q1-P17)

*Unique concepts and tasks.* “Through caring, professional nurses enact the uniqueness of nursing and their conviction that nursing practice can make a difference in the health of individuals, families, aggregates or cultures” (Newman, Sime & Corcoran-Perry, 1991, p. 2).

- To me, the forensic nursing courses are really conceptualized as nursing. It’s nursing first and you’re looking at the *unique* attributes the client presents with; the *unique* problems the client presents with. (Q2-P01)

- Certainly some of the *unique* tasks of nursing are different from other disciplines, for example, medication administration and supervision and evaluation of the impact of medication. (Q5-P01)
- Forensic nursing is *unique* because some of the assessments the nurses might do, particularly in the physiological domain, are *unique* to nurses. (Q5-P01)
- Forensic nursing is *unique* because the things that are *uniquely* forensic, I think, are those things that stem directly from forensic medicine, or forensic science: the concepts, the factors of documentation, and steps in investigation and analysis. (Q5-P11)

*Unique knowledge.* Mason and Carton (2002) noted “one point of uniqueness, although difficult to define, is highlighted in the literature as the contrasting aims of caring and custody” (p. 541). A few examples present in the data were:

- I think the *unique* knowledge of forensic nursing is that higher level evidence for how do we promote health and healing through a caring paradigm. (Q5-P10)
- To me the *unique* knowledge is emerging, and I struggle with not only how to teach, but what to teach. And for me that’s evolving. I think that there is a lot, what makes the knowledge *unique*. (Q5-P10)

#### *Constructed Connotations of Unique Prefix Typology*

In constructing a definition of forensic nursing, there was strong indication, both from the data of this study and from the literature that the *unique* knowledge of forensic nursing should be determined, and that *unique* was separate knowledge from *different*. This *unique* knowledge would be an important concept to include in the definition of forensic nursing.

- ❖ Forensic nursing is *unique* because it serves or cares for both the population of victims, and perpetrators of violence, in a way that they haven’t been served before.

### *Typology 5.1D. Law/Legal Prefix*

*Legal* was often used as a descriptor, an adjective or a prefix just as *forensic* was frequently used as a prefix. The terms *law* and *legal* seems to have a prominent place in the definition and conceptualizations of forensic nursing (See Table 5.1D. Typology: Legal Prefix).

#### *Literature Comparisons to Law/Legal Prefix Typology*

Two definitions of forensic nursing in the literature include the legal prefix as follows: “Forensic nursing is based on the integration of forensic science, criminal justice, and nursing science in a unique application of the nursing process to legal proceedings” (Bell & Benak, 2001, p. 1). Also, forensic nursing is an umbrella term that includes subspecialties of the nursing discipline in which the art and science of forensic nursing’s clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters (Kent-Wilkinson, 2006).

Table 5.1D.

#### *Typology: Legal Prefix n=11*

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##### *Data Extracts*

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##### *Legal Prefix (8)*

- legal aspects. (Q2-P07)
- legal component. (Q2-P07)
- legal events. (Q 2-P11)
- legal field. (Q 1-P12)
- legal parameter. (Q 1-P07)
- legal principles. (Q 2-P07)
- legal realm. (Q 1-P12)
- legal system. (Q 1-P05) (Q 1-P06) (Q 1-P19)

##### *Law (3)*

- law enforcement. (Q 1-P03)
- pertains to the law. (Q 1-P01)
- principles of law. (Q 1-P06)

##### *Literature comparisons*

- legal proceedings” (Bell & Benak, 2001).
- legal issues in legal contexts embracing civil, criminal, correctional or legislative matters (Kent-Wilkinson, 2006).

Total = 11

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Examples of data extracts where the legal prefix was used were:

- Forensic nursing is nursing that in some way pertains to the *law*. (Q 1-P01)
- Individuals who have in common some sort of *legal* component to their health care. (Q 2-P07)
- Forensic nursing is the intersection of nursing science and practice with the *legal* system. (Q 1-P06)
- Anything that is nursing practice that has a *legal* parameter is going to be part of the practice of forensic nursing. (Q 1-P07)

### *Constructed Connotation of Law/Legal Prefix Typology*

Legal nurse consultants focus on the legal aspects of their practice, but their discipline is nursing not law, and they are not lawyers. In constructing a definition of forensic nursing, there was a strong indication both from the data of this study and from the literature that the *legal* aspects of forensic nursing would be an important concept to include.

- ❖ Forensic nursing is nursing that in some way pertains to the *law*.

### *Typology 5.1E. Law/Legal Relationship*

In responding to the first question “What is forensic nursing?” the *connection* between nursing and the law is described using many different verbs (See Table 6.1E. Typology: Law/Legal Relationship). Of the 17 different verbs used, *interfacing* and *intersecting* were used most often.

### *Literature Comparisons to Law/Legal Relationship to Nursing Typology*

An example from the literature relevant to this study using the term *intersection* to law/legal was a definition by Lynch that was adopted by the IAFN Board: “Forensic nursing is defined as the global practice of nursing when health care and legal systems intersect” (IAFN, 2006).

Table 5.1E.

*Typology: Law/Legal Relationship 1**17 verbs to describe forensic nursing's relationship to the law and to the legal system*


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1 = application of legal component. (Q 2-P07)	3 = interfacing with the law. (Q1-P05, Q1-P11, Q1-P16)
1 = associated with the legal events. (Q 2-P11)	1 = integrating with the law. (Q1-P06)
2 = collide with the law. (Q1-P09)	3 = intersecting with the legal system. (Q1-P06, Q1-P07, Q1-P19)
2 = coincide with the criminal justice system. (Q1-P01)	1 = involvement with the law. (Q1-P10)
2 = combination of nursing and law. (Q1-P09, Q1-P15)	2 = legal field implications. (Q1-P12, Q1-P17)
2 = connection with the law. (Q1-P11)	1 = liaison with the law enforcement
2 = contact with the legal system. (Q1-P01, Q1-P02)	/medicine/criminal and civil systems. (Q1-P03)
1 = cross into legal realm. (Q1-P12)	2 = pertaining to the law. (Q1-P01, Q1-P15)
1 = deal with the legal aspects. (Q2-P07)	2 = synthesizing with the law. (Q1-P06, Q1-P07)
Total = 17 verbs	

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A few of the numerous examples of data extracts from this study were:

- Forensic nursing *interfaces* with the law. (Q1-P11)
- Forensic nursing is nursing that in some way *pertains* to the law or where nursing and health care *coincide* with the criminal justice system in some way. (Q1-P01)
- Forensic nursing is the *intersection* of nursing science and practice with the legal system. It occurs across multiple domains but requires the ability to *synthesize* these legal systems to provide service to clients. (Q1-P06)
- Forensic nursing is the *interaction* that we as nurses have with patients will also have an implication in the legal field. (Q 1-P12)
- Forensic nursing is where nurses work with patients, who have a high likelihood of *interfacing* with one of the justice systems, whether that be a civil justice system or a criminal justice system. (Q 1-P16)
- Clinical forensic nursing involves primarily living patients who are either offenders or who are victims or individuals who vicariously are *associated* with the legal events that occur in a health care setting. (Q 2-P11)

*Constructed Connotations of Law/Legal Relationship Typology*

All participants expressed that forensic nursing involved some *connection* between nursing, health care, and the law. They described it in the following ways:

*pertaining to the law, interfacing with the law, coinciding with the legal system, colliding with the law, interacting with the legal system, synthesizing with the law, liaisons with law enforcements, implication with the legal field, intersecting with legal issues, contact with the law, crossing into the legal realm, and practicing within the legal system.* In constructing a definition of forensic nursing, there was a strong indication both from the data of this study and from the literature that the *relationship* of forensic nursing to the *law* is important concept to include.

- ❖ Forensic nursing *interfaces* with the law.
- ❖ Forensic nursing is the *intersection* of nursing science and practice with the legal system.

#### *Typology 5.1F. Specialty Prefix*

The prefix *specialty* was often used in this study to describe many aspects of forensic nursing (See Table 5.1F. Typology: Specialty Prefix).

Table 5.1F.

*Typology: Specialty Prefix /Specialization*

<i>Data Extracts</i>	<i>Literature Comparisons</i>
<ul style="list-style-type: none"> <li>• specialty area. (Q1-P01)</li> <li>• specialized arena. (Q5-P05)</li> <li>• specialized elective courses. (Q10-P01)</li> <li>• specialized field. (Q 5-P01)</li> <li>• specialty population. (Q1-P01)</li> <li>• specialized role. (Q 5-P05)</li> </ul>	<ul style="list-style-type: none"> <li>• specialty status (Martin 2001)</li> <li>• specialized study (Hammer, 2000).</li> <li>• specialist skills and knowledge (Baxter, 2002).</li> <li>• forensic specialist opinion (Friel &amp; Chaloner, 1996).</li> </ul>

#### *Literature Comparisons to Specialty Status Theme*

*Specialty status of forensic nursing.* Correctional nursing was recognized as a nursing specialty in 1984, and the Scope and Standards of Nursing Practice in Correctional Facilities was passed the same year by the American Nurses Association

(ANA, 1984). Forensic nursing was recognized as a formal specialty in 1995 by the American Nurses Association (ANA, 1995) and in 1997 the Standards and Scope of Practice developed by the members of the International association was approved by ANA. “Forensic nursing, one of the newest specialty areas recognized by the ANA is gaining momentum nationally and internationally” (Burgess, Berger & Boersma, 2004, p. 59).

Examples from the data of this study were:

- The American Academy of Forensic Sciences was the very first, even before nursing, to recognize forensic nursing as the scientific discipline. That was in 1991. (Q9-P08)
- And then finally the American Nurses Association has, in 1995 when they ...acknowledged forensic nursing as a *specialty* not a sub-specialty, that gave some political justification to this as a specialty. (Q9-P16)

*Question of specialty status.* A question frequently debated in the literature was, Is forensic nursing a unique *specialty* area or simply nursing applied to *special* population or environment? Mason and Carton (2002) noted that in forensic nursing, debate is centered on two points: whether generalist principles of professional working practices are merely being applied to a specific patient population; and, whether there is a unique body of knowledge known as a forensic nursing *specialty*. This debate was evident in the following data extracts:

- I struggle sometimes with: is forensic nursing a unique *specialty* area or is it nursing applied to a *specialty* population or a special environment. (Q1-P01)
- A specialty in nursing is forensic NOT a nursing *specialty* in forensics. (Q2-P08)
- Obviously our major status is nursing. Our *specialty* in nursing is forensic. But first and foremost, we’re always a nurse. I have to tell my students frequently as they don’t want to take the nursing courses, they just want to take forensic nursing, and I tell them you can’t do that because first you



have to be a good clinician and only then, can you apply forensic science to your clinical practice. And if you're not a good clinician, you're not going to be a good forensic nurse. (Q2-P08)

One participant's perspective was that forensic nursing was *not* a *specialty*:

- I don't think forensic nursing is a *specialty*. It is simply nursing care of patients who happen to be victims or offenders where that care interfaces with the law. (Q1-P7)

*Need for educational infrastructure.* Robinson and Kettles (1998) noted that psychiatric nurses challenged if there was a specialty area of forensic nursing because of the "absence of a clear educational pathway into the area" (p. 217). Although some groups of nurses accepted forensic nursing as a *specialty*, others still questioned if it was a *specialty*, because there was not an educational infrastructure in place. Recognition of a *specialist* area of practice is greatly advanced with educational tracks that lead to *specialization* of the discipline. In recognition of the need to enhance the career pathways for forensic nursing, course development was first essential for the awareness of this *specialty* of nursing practice. An example extract from data was:

- The key was that when nursing educators recognized that this *specialty* was one that was needed, they did not have an infrastructure to address it. (Q11-P19)

*Forensic psychiatric nursing.* Forensic nursing can justifiably claim the status of a specialty, "with its distinctive client group, predominantly institutional based care, exceptional knowledge base and a clinical focus on mental disorder and deviance" (Burrow, 1993, p. 899). Generic mental health teams face anxieties and pressures in caring for/ managing difficult/ dangerous patients, which is reflected in the number of

requests for forensic specialist opinion (Friel & Chaloner, 1996). An example from the data was:

- Forensic nursing is certainly a *specialization*. (Q11-P05)

#### *Constructed Connotations to Specialty Status Theme*

From a constructivist perspective forensic nursing is both a recognized *specialty* area, and it is also nursing applied to a *specialty* population or a *special* environment. The American Academy of Forensic Sciences first recognize forensic nursing as a scientific specialty in 1991, then by nursing in 1995 when the American Nurses Association recognized forensic nursing as a formal specialty by (ANA, 1995). Constructed definitions with regard to the *specialty* states are:

- ❖ Forensic nursing is a *specialty* of nursing, where nursing cares for complex forensic populations of victims, offenders, living and deceased, and where that care interfaces with the law
- ❖ Forensic nursing is both a unique *specialty* area, and it is nursing applied to a *specialty* population or a special environment.

#### *Typology 5.1G. Emerging/Evolving Prefix*

Some participants stated that forensic nursing was a process that is *emerging* and *evolving*, and that it is a function rather than an umbrella. When articulating what forensic nursing was, many educators expressed it was a definition, a concept and a process that has *emerged* and *evolved* (See Table 5.1G. Typology: Emerging/ Evolving).

#### *Literature Comparisons to Emerging/Evolving Specialty Theme*

The literature frequently used the *emerging/evolving* prefix to describe the forensic nursing specialty. As a specialty forensic nursing is considered to be still *emerging* and *evolving*.

Table 5.1G

*Typology: Emerging/evolving Prefix  
(verb & adjective) n=3*

<i>Data Extracts</i>	<i>Literature Comparisons</i>
<ul style="list-style-type: none"> <li>• emerged</li> <li>• emerging/evolving specialty</li> <li>• emerging roles</li> <li>• emerging social priorities. (Q 2-P10)</li> <li>• evolved. (Q1-P10)</li> <li>• evolving. (Q5.P05)</li> </ul>	<ul style="list-style-type: none"> <li>• emerging specialty (Gudgeon, 2004).</li> <li>• emerging role (Gudgeon, 2004).</li> </ul>

*Evolving specialty.* The practice of nursing continues to *evolve* to meet the changing health needs of clients. Changes in the delivery of health care are providing opportunities for nurses to create new roles and expand current roles. New roles in nursing must develop in ways that promote excellence in client-centered care and that are in the public's best interests (CNA, 2002a; CNA, 2002b). One example from the data was:

- Forensic nursing *evolved* from the need to increase the care to victims and perpetrators, some from societal need and some from our own need to improve the services. (Q1-P10)

*Emerging roles/specialty.* As an *emerging* specialty, the role of the forensic psychiatric nurse is not yet universal, and the term *forensic* has expanded to include nurses working with both victims and perpetrators in a variety of settings. The *emerging* role of the forensic psychiatric nurse, the debate over the existence of a specialty, role tensions, and training issues (Gudgeon, 2004) are areas of discussion in the literature. A few examples present in the data were:

- A lot of opportunities in forensic nursing *emerged* because people saw this sexy, different, possibly more powerful, more aligned with medicine, more prestigious opportunities in which to apply their nursing skills. (Q 2-P10)
- You can never leave politics and *emerging* social priorities out of where we seem to find ourselves. (Q 2-P10)
- To me the unique knowledge is *emerging*, and I struggle with, not only how to teach, but what to teach. And for me that's *evolving*. I think that there is a lot, what makes the knowledge unique. (Q 5-P10)

### *Constructed Connotations to Emerging/Evolving Specialty Theme*

A constructed interpretation relevant to this study would be:

- ❖ Forensic nursing *evolved* from the need to increase the care to victims and perpetrators, both from societal need and from our own need to improve the services.
- ❖ As the unique knowledge of forensic nursing *emerges* and *evolves*, educators themselves struggle with, not only how to teach, but also what to teach.

### *Typology 5.1H. Forensic Population*

Historically, the term *patient* was the word used to describe for whom nurses care.

In the Nursing Standards of Practice in both countries the professional associations are adopting the word *client* to describe the one for whom nurses provide health care services. The thinking is that the term *client* is more empowering than the term of *patient* which may imply a more helpless context.

In this study, the respondents referred to the populations they cared for as *patients* n = 9/16, almost twice as often as they used the term *client* n = 5/16. The term *victims* was used more often than survivors for references to patients who were victims of violence, but both terms were used in context. The term *perpetrator* was used slightly more than offender. In addition, a variety of other terms for *perpetrator* were also used periodically (See Table 5.1H. Typology: Forensic Populations).

Table 5.1H.

*Typology: Forensic Populations n=26*

*26 words used to describe the forensic patient population served by nurses*

<i>Populations n=6</i>	<i>Patient n=7</i>	<i>Offenders n=7</i>	<i>Victims n=6</i>
At risk populations. (Q5-P01)	Patients n=9	Offenders	Victims
Incarcerated population. (Q6-P07)	Clients n=6	Perpetrators	Survivors
Marginal populations. (Q6-P17)	Families	Inmates	Complainant
Particular population. (Q1-P11)	Aggregate	Individuals	Constituents
Special population. (Q1-P10)	Person	Suspects	Deceased
Vulnerable populations. (Q5-P01)	People	Criminals	Plaintiff
	Service users	Assailant	

<i>Offender Populations</i>	<i>Victim Population</i>	<i>Deceased Population</i>
<ul style="list-style-type: none"> <li>• Aboriginal Offender</li> <li>• Addicted offender</li> <li>• Aging Offender</li> <li>• Culturally Diverse Offender</li> <li>• Dangerous Offender</li> <li>• Disabled Offender</li> <li>• Family of Offenders</li> <li>• Female Offender</li> <li>• Mentally Disordered Offender</li> <li>• Sex Offender</li> <li>• Young Offender</li> </ul>	<ul style="list-style-type: none"> <li>• Child abuse/neglect</li> <li>• Domestic violence</li> <li>• Elder abuse/neglect</li> <li>• Sexual assault</li> <li>• Terrorism</li> <li>• Trauma</li> <li>• Victims of violence</li> <li>• Living</li> </ul>	<ul style="list-style-type: none"> <li>• Suspicious death</li> <li>• Accidental death</li> <li>• Homicidal death</li> <li>• Unnatural death</li> <li>• Unexpected death</li> </ul>

<i>Literature Comparisons</i>
<ul style="list-style-type: none"> <li>• At Risk population (Clark, 1996).</li> <li>• Client group (Burrow, 1990, p. 899).</li> <li>• Client population (Doyle, 1999, p. 34).</li> <li>• Marginalized population (Sekula et al., 2001).</li> <li>• Offender Populations (Paternelj-Taylor &amp; Johnson, 1995).</li> <li>• Vulnerable population (Thesaurus: English/US, 2006).</li> <li>• Victims of sexual and domestic assault, child and elder abuse, gun shot and motor vehicle accidents (Naiman, 2006).</li> </ul>

### *Literature Comparisons to Forensic Population Typology*

The forensic population in the literature is often referred to as *vulnerable*, *at risk*, *marginalized*, or *susceptible* groups to violence. These terms are often used in the epidemiology literature.

*Risk population.* The concept *risk population* originated in epidemiology. When epidemiologists speak of *populations at risk*, they are referring to groups of people who have the greatest potential to develop a particular health or social problem because of the presence or absence of certain contributing factors (Clark, 1996). The concept of *vulnerable population* means susceptible (n.) weak, defenseless, helpless, at risk, in danger, in a weak position (Thesaurus, 2007). A few of the examples present in the data were:

- The *population* is *vulnerable*, *at risk* or *susceptible* to violence or *perpetrators* of violence or tragedy. I go back to *vulnerable populations* and who the forensic client is you might see within a forensic psychiatric hospital or within a correctional institution. (Q5-P01)
- Forensic [Psychiatric Correctional] Nursing is really providing care to *mental ill offenders* and to the *incarcerated population* and that is where the law component comes into play. (Q1-P01)
- Forensic nursing is simply the care of *special population* that happens to be involved with either the criminal justice system or involved with basic issues of either violence or crime. (Q1-P10)
- Forensic nursing is unique because it serves the *population* of *victims* of violence, and *perpetrators* in a way that they haven't been served before. (Q1-P17)

*Client population/group.* A person with whom the registered nurse is engaged in a therapeutic relationship. In most circumstances, the *client* is an individual but may also include family members and/or substitute decision-makers. The SRNA (2007) stated that the *client* can also be a group (e.g., therapy), a community, (e.g., public health), or a

population (e.g., children with diabetes). Doyle (1999) observed that “Corrections Psychiatric Mental Health [PMH] nurses deliver care to a unique and challenging client population” (p. 34). Examples present in the data were:

- Awareness that our interactions with these *client populations*, possibly has a legal implication. (Q1-P12)
- Our *patients*...our *constituents*, our *clients*, or our *members*, forensic nursing can also be the mentoring and building of our own *members* of our profession. (Q5-P07)
- These were *incarcerated individuals* were often coming for care, in our Emergency Rooms. (Q6-P07)
- Forensic nursing is where nurses work with *patients*, who have a high likelihood of interfacing with one of the justice systems, whether that be a civil justice system or a criminal justice system. (Q1-P16)

*Victims/offenders*. Graduates will learn to give better care to *victims* of sexual and domestic assault, child and elder abuse, gun shot wounds, and motor vehicle accidents (Naiman, 2006). Examples present in the data were:

- Whether they are the *perpetrators* or whether they are *survivors*. Forensic nursing is necessary for meeting the complex care of the *clients* (Q1.P03).
- Either offender or victim. (Q2-P02)
- Not *victim* or *offender* but the *person*. (Q3&4-P15)
- I like to have numbers of people respond to either the *victim* or the offender. We’re having trouble with concepts like the *victim* in these cases, the *offender* was victimized, and that’s why the person is acting the way they are. Have them put in an *offender* box. And, this is a bad person because he did these things. I don’t like that he did these things, but maybe we could talk about how he got there. (Q3&4-P15)

### *Constructed Connotation of Forensic Population Typology*

The participants in this study used different terms to describe those for whom forensic nurses care. Two participants explained how they took exception to the patients being referred to by so different terms or did not think they should be referred to anything other than *patients*. Examples from the data were:

- I believe it is a disservice to the people we serve or care for when every discipline calls the person a different name and they are the same people. Many words for *patients* ...there all the same *person*. The police call them victims, the court system calls them the complainant, nurses and physicians use the word *patient*, and we all have to know what each others role is, and I, I think, *patients*, slash *victims*, slash *complainant* have been really, really a disservice. (Q2-P09)
- One of the sort of philosophies that we work with is that we work with *patients*. I do not teach the nurses in the program *victim* care, I don't teach them *survivor* care. As nurses, our charge is to provide *patient* care. So that's a focus of what we're doing in that it keeps our objectivity very up front, and we are working with *patients*, and not going into the criminal justice language of referring to the people we serve as *victims*. (Q3-P16)

Unique to forensic nursing, the *forensic* or *patient population* that nurses care for consists of both *victims* and *offenders* who need forensic nursing services. Of the 21 nouns used to describe the forensic nursing *population*, many words were used to describe both *victims*, as well as *offenders*, in addition to the *patient/client* term used in the nursing discipline generally. Within the nursing profession, and from a constructivist approach, all terms are relevant in describing the *populations* we provide services to. Examples of constructed interpretations with regard to definitions of forensic *populations* are:

- ❖ Forensic nursing is unique because it serves the *population* of *victims* of violence and *perpetrators* in a way that they haven't been served before.
- ❖ Forensic nursing is a way to improve services for *victims*, ensure that their needs are met, and a way to reduce crime by holding criminals or assailants accountable.
- ❖ The forensic *population* is often referred to as vulnerable, at risk, marginalized, or susceptible groups to violence.
- ❖ Forensic nursing is necessary for meeting the complex care of *persons* (*patients* or *clients*) whether they are the *perpetrators*, or whether they are *survivors*, or for the needs of the *deceased* and their *families*.



### *Typology 5.II. Forensic Systems and Services*

Forensic *systems* and *services* have relevance to this study as forensic nursing and its many subspecialties care for patients/clients within many forensic *systems* and forensic *services*. In addition to the health care *system*, forensic nurses are employed in: the criminal justice *system*, the child welfare *system*, the medical examiner/coroner *system*, and the mental health care *system*. Forensic nurses practice in the unique environments of a variety of forensic *services*: sexual assault clinics, emergency departments, jails, and penitentiaries (See Table 5.II. Typology: Forensic Systems and Forensic Services).

Table 5.II

*Typology: Forensic Systems and Forensic Services*  
*n=9+7*

<i>Data Extracts</i>	<i>Literature Comparisons</i>
<p><i>Forensic Systems n=9</i></p> <ul style="list-style-type: none"> <li>• civil justice system. (Q1-P16)</li> <li>• coroner system. (Q1-P08)</li> <li>• criminal justice system. (Q1-P16)</li> <li>• educational system. (Q5-P01)</li> <li>• health care system. (Q5-P01)</li> <li>• Individual and family system. (Q5-P01)</li> <li>• legal system. (Q1-P06)</li> <li>• medical examiner system. (Q1-P08)</li> <li>• mental health system. (Q1-P01)</li> </ul>	<p><i>Forensic Systems</i></p> <ul style="list-style-type: none"> <li>• judicial/ penitentiary system (Gudgeon, 2004).</li> <li>• unique social system (Doyle, 1999)</li> <li>• medical examiner/coroner system</li> </ul>
<p><i>Forensic Services n=7</i></p> <ul style="list-style-type: none"> <li>• correctional facilities. (Q6-P07)</li> <li>• emergency department. (Q6-P17)</li> <li>• hospital (Q6-P07)</li> <li>• jails (Q6-P10)</li> <li>• medium secure units. (Q5-P01)</li> <li>• prisons (Q5-P01)</li> <li>• sexual assault clinic. (Q6-P09)</li> </ul>	<p><i>Forensic Services</i></p> <ul style="list-style-type: none"> <li>• secure psychiatric settings (Gudgeon, 2004).</li> <li>• medium secure units</li> </ul>

### *Literature Comparisons to Forensic Systems/Services Typology*

Forensic nurses have learned to interface with, and navigate through many *systems*, not only health care, but also the criminal justice, child welfare, medical examiner/coroner, and the mental health care *system*. The literature provided some of the following references:

*Prison systems/services.* Forensic *systems* and *services* are frequently mentioned in the forensic psychiatric/correctional literature. “Prison is a unique social system, where inmates live, unwillingly and resentfully in a highly structured and regulated environment” (Doyle, 1999, p. 31). Forensic psychiatric nurses work with offenders who have been deemed mentally disordered and thus have no place in the judicial/penitentiary *system* (Gudgeon, 2004). Within secure psychiatric settings, they must provide care for and maintain custody of these patients, a paradoxical role that makes this type of nursing unique (Gudgeon). “The locus of overcrowding and commitment pressures within prisons systems has ensured that nurses continue to share many of its less than optional conditions of their offender clients” (Doyle, p. 35). Examples from the data were:

- But in addition we also had a lot of women who were delivering babies who were from the local *correctional facilities* because we were the hospital that would provide that care so you learn to take care of these patients. (Q6-P07)
- Forensic nursing is where nurses work with patients, who have a high likelihood of interfacing with one of the justice *systems*, whether that be a civil justice system or a criminal justice *system*. (Q1-P16)

*Multiple systems/services.* Forensic nurses practice not only in the complex organizations of hospitals within the health care system, but also in facilities of many

interfacing systems: the criminal justice system, the mental health care system, the medical examiner/coroner system, the child welfare system, and in government approved facilities. Forensic nurses have adapted to practices within many systems, and with many disciplines on interdisciplinary teams, but their practice remains within the scope of nursing (Kent-Wilkinson, 2006).

- Forensic nursing is the intersection of nursing science and practice with the legal *system*. It occurs across multiple domains but requires the ability to synthesize these legal *systems* to provide service to clients. (Q1-P06)
- It involves the justice system, the educational *system*, and the health care *system*, just to mention a few (inaudible). (Q5-P01)
- So acknowledging that we are crossing into other *systems*. It's important that we also hear from those *systems*. So they are actually a part of the training. (Q6-P12)

#### *Constructed Connotations of Forensic Systems/Services Typology*

In constructing a definition of forensic nursing, there is a strong indication, both from the data of this study, and from the literature that the *systems* in which forensic nurses work are multiple and unique. *Systems* is also a concept that is often included in definitions of forensic nursing. Of note, in the analysis, the qualifier *high likelihood* or *more likely to* became an important clarifier of the constructed definitions.

- ❖ Forensic nursing is where nurses work with patients, who have a *high likelihood* of interfacing with one of the justice *systems*, whether that be a civil justice *system* or a criminal justice *system*.

#### *Typology 5.1J. Forensic Focus*

In all health specialties the *focus* of care is one of the significant points of uniqueness of that specialty. The word *focus* in this study is frequently used in place of or with the term *forensic* (See Table 5.1J. Typology: Forensic Focus).

Table 5.1J.

*Typology: Forensic Focus*  
*n=6*

<i>Data Extracts</i>	<i>Literature Comparisons</i>
<ul style="list-style-type: none"> <li>• forensic focus. (Q3&amp;4-P16)</li> <li>• focus on forensic. (Q5-P20)</li> <li>• focus of the interview. (Q3&amp;4-P17)</li> <li>• focus of care</li> <li>• disease focus. (Q1-P19)</li> <li>• health focus. (Q1-P19)</li> </ul>	Focus of care (Newman, Sime, & Corcoran-Perry, 1991, p. 3).

#### *Literature Comparisons to Forensic Focus Typology*

When the *focus* of nursing is referred to in the literature, it is most often stated that caring is the *focus* of nursing. Newman, et al., (1991) have written that “nursing is the study of caring in the human health experience” (p. 3). This *focus* integrates into a single statement concepts commonly identified with nursing at the metaparadigm level. This *focus* implies a social mandate and service identity specifies a domain of knowledge development. Examples of data extracts where the word *focus* was used in this study were:

- Nursing is health *focused* and comprehensive, unlike medicine which is disease focus. (Q1-P19)
- They take a lot of the same courses that all of the clinical nurse specialists take in any subject area, but what their getting is a forensic *focus*, so they are first and foremost clinical nurse specialists, and that again is driving the philosophy of the program as to the advanced practice nurse, not a criminologist or an investigator. It’s a forensic *focus*. (Q4-P16)
- In the past, nurses and physicians, and other health care workers, *focus* on the patient injuries when they come in, and, but not on the role of violence in those injuries, so that we didn’t really assess for, how they were violated in any way. (Q5-P17)
- Our forensic nursing practice has to be in the forefront as a forensic *focus*. (Q5-P20)

- In the forensic interview, the *focus* is somewhat different, in that we're looking at what another person did to them. (Q5-P20)
- Many graduate and doctoral and DNP programs in the United States now have a forensic *focus* or track as an educational stream. (Q5-P19)

### *Constructed Connotations of Forensic Focus Typology*

In constructing a definition of forensic nursing, there is a strong indication both from the data of this study and from the literature that the *focus* of care is a concept that should be included in a definition of forensic nursing.

- ❖ Forensic nursing not only *focuses* on the care of the injury, but also on the role of violence in those injuries.

### *Typology 5.1K. Forensic Care*

In this study the action described by the participants of what forensic nurses do, is most often *care*; however, other words used were *serve*, *work*, and *interact* (See Table 5.1K. Typology: Forensic Care).

### *Literature Comparisons to Forensic Care Typology*

Care in the forensic nursing literature is found in many contexts. Care refers to the practice of nursing where *care* and many other terms are used to describe the service, in addition care is used in the context of the *caring* philosophy and a *caring* discipline.

*Care and other terms.* The forensic nursing literature frequently describes the forensic *care* of patients. Graduates will learn to give better care to victims of sexual and domestic assault, child and elder abuse, gun shot wounds, and motor vehicle accidents (Naiman, 2006). In the nursing profession in general many adjectives are used and are acceptable terms to describe the work or care that nurses provide. The participants in this study used a variety of terms in addition to *care* to describe the action of forensic nursing.

Table 5.1K.

*Typology: Forensic Care**6 words to describe care or action by forensic nurses*

<i>Words to describe Caring Action by Nurses</i>	<i>Types of Care</i>	<i>Philosophy</i>
5 = Care (Q1-P01, P03, P10, P12, P16) 3 = Serve, provides a service, improves service. (1-P17) 2 = Works with. (Q1-P16) 1 = Interacts with. (Q1-P12) 1 = Maintaining health and protection of the community	<ul style="list-style-type: none"> <li>• Complex care</li> <li>• Comprehensive care</li> <li>• Health care</li> <li>• Nursing care</li> <li>• Patient care</li> <li>• Survivor care</li> <li>• Victim care</li> <li>• Continuous care</li> </ul>	<ul style="list-style-type: none"> <li>• Caring disciplines (Q5-P01)</li> <li>• Caring paradigms (Q5-P10)</li> <li>• Caring philosophies (Q5-P10)</li> </ul>
<i>Literature Comparisons</i>		
<ul style="list-style-type: none"> <li>• health care (Lynch, 1990, p. 49).</li> <li>• nursing care (Rask &amp; Aberg, 2002)</li> <li>• care to victims (Naiman, 2006).</li> <li>• concept of caring (Benner &amp; Wrubel, 1989; Leininger, 1984; Watson, 1985).</li> <li>• caring and the human health experience (Newman, et al., 1991, p. 3).</li> <li>• caring focus (Newman, et al., 1991, p. 3).</li> <li>• caring and custody (Mason &amp; Carton, 2002).</li> <li>• needed care as well as to be in custody (Sekula, et al., 2001).</li> </ul>		

Examples present in the data were:

- Forensic nursing incorporates intrinsic values of *caring* and health promotion and advocacy embedded in nursing. It competes with other roles that implement forensic science that happens to be occupied by nursing. (Q1-P10)
- Forensic nursing is the *interaction* that we as nurses have with patients will also have an implication in the legal field. (Q1-P12)
- Forensic nursing is where nurses *work* with patients, who have a high likelihood of interfacing with one of the justice systems, whether that be a civil justice system or a criminal justice system. (Q1-P16)
- Forensic nursing is unique because it *serves* the population of victims of violence, and perpetrators in a way that they haven't been served before. (Q1-P17)

*Concept of caring philosophy/discipline.* The concept of *caring* has occupied a prominent position in nursing literature and has been touted as the essence of nursing (Benner & Wrubel, 1989; Leininger, 1984; Watson, 1985). Nursing is the study of *caring* in the human health experience. “A body of knowledge that does not include caring and human health experience is not nursing knowledge” (Newman, et al., 1991, p. 3).

Examples from the data were:

- That *caring* philosophy permeates not just the courses but the programs and indeed for me, what I think nursing is. And if they’re not all the same, than I think that’s where we get into trouble, in terms of education. (Q3-P10, Q4-P10)
- Although I do recognize that nursing isn’t the only discipline that calls itself a *caring* discipline. But I mean that has been our contribution in many regards. But it’s unique. (Q5-P01)

*Care and custody.* Sekula, et al., (2001) noted that the discourse on forensic nursing produced a form of knowledge in which patients needed care as well as to be in custody (See Dual Roles Theme in Chapter Six). An example in the data of this study was:

- Forensic [psychiatric/correctional nursing] is really the *care* of people who have come into conflict with the law and are either remanded for psychiatric evaluation or are sentenced and incarcerated and require health care during that time. (Q1-P01)

### *Constructed Connotations of Forensic Care Typology*

In constructing a definition of forensic nursing, there is a strong indication both from the data of this study and from the literature that any knowledge that does not include *care* is not describing nursing or any specialty of nursing. “A body of knowledge that does not include caring and human health experience is not nursing knowledge” (Newman, et al., 1991, p. 3). Nursing used multiple terms to describe *care*;

terms used in this data set are: *interacts with*, *work with*, and *serve*.

- ❖ Nursing's philosophical base is the *caring* paradigm, therefore forensic nursing also adheres to this philosophy.
- ❖ Forensic nursing incorporates intrinsic values of not only *caring*, holism, health promotion, illness prevention, but also scientific objectivity and advocacy embedded in nursing.
- ❖ Forensic nursing *serves* both the population of victims of violence and perpetrators in a way that they haven't been served before.

Also different adjectives were used to describe *care* in this study or as a prefix to *care* (e.g., complex, continuous, and 24 hour/7 days a week/365 days a year (24/7/365) care). In the analysis it became evident that how forensic nursing *care* was different from nursing, and different from other forensic disciplines had significance in this study (See Theme 5.3, Knowledge Differentiation).

#### *Typology 5.1L. Forensic Nursing Role*

The data described 22 different *roles* for the forensic nurse, some of which were a description of the *roles*, and others were the responsibility or *role* task (See Table 5.1L. Typology: Forensic Nursing Role).

#### *Literature Comparisons to Forensic Nursing Role Theme*

Hufft and Peternelj-Taylor (2000) have concluded that clarification of the professional role of the forensic nurse is dependent not only on what the nurse does (role expectations) but also on where the nurse works (role setting). The literature used many of the same terms evident in the data extracts of this study to describe the *role* of forensic nurse: *broad*, *crucial*, *caring*, *complex*, *expanding*, *dual*, *emerging*, *evolving*, *nursing*, *paradoxical*, and *professional*.



Table 5.1L.

*Typology: Forensic Nursing Role (22)*

<i>Role of Forensic Nurse Described in Data</i>	<i>Literature Comparisons to Role Theme</i>
<ul style="list-style-type: none"> <li>• advanced nursing practice role. (Q5-P17)</li> <li>• broader forensic nursing role. (Q9-P12)</li> <li>• court testimony role. (Q11-P19)</li> <li>• dual roles. (Q8-P01)</li> <li>• emerging nursing role.s (Q1-P10)</li> <li>• established role. (Q1-P10)</li> <li>• expanded role. (Q6-P12)</li> <li>• expert testimony role. (Q11-P19)</li> <li>• forensic role. (Q9-P12)</li> <li>• forensic nursing role. (Q9-P12)</li> <li>• global role on the forensic team. (Q5-P05)</li> <li>• independent practice role. (Q9-P12)</li> <li>• independent and progressive role. (Q12-P02)</li> <li>• new roles. (Q2-P10)</li> <li>• nursing role. (Q1-P10)</li> <li>• nurse practitioner. (Q12-P02)</li> <li>• other roles. (Q1-P10)</li> <li>• progressive role. (Q12-P02)</li> <li>• handmaiden to the physician. (Q12-P05)</li> <li>• physician's role. (Q10-P12)</li> <li>• role in connection with community. (Q5-P01)</li> <li>• role as an individual in society. (Q5-P01)</li> </ul>	<ul style="list-style-type: none"> <li>• broad role (Baxter, 2002)</li> <li>• caring role (Ewers, et al., 2002).</li> <li>• complementary role (Baxter, 2002)</li> <li>• complex role (Hammer, 2000).</li> <li>• crucial role (Blair, 2002)</li> <li>• dual roles (Du Mont &amp; Parnis, 2003).</li> <li>• dichotomy of roles (Hammer, 2000).</li> <li>• distinct role (Gudgeon, 2004)</li> <li>• emerging role (Gudgeon, 2004).</li> <li>• evolving role (Friel &amp; Chaloner, 1996).</li> <li>• not exclusively a nursing role (Hanson &amp; Hamric, 2003)</li> <li>• nursing role (Baxter, 2002)</li> <li>• paradoxical role (Gudgeon, 2004).</li> <li>• unique role (Gudgeon, 2004).</li> </ul>

*Broad or global role.* In the United Kingdom, Baxter (2002) conducted a descriptive study to investigate the perceptions of nurses who worked in a secure environment to their roles and skills. Baxter's findings suggested that nurses in these environments had a broad role and possessed a range of skills and personal qualities.

Example from the data were:

- Forensic nursing has a broad *role* covering many aspects of nursing. (Q8-P06)
- Other people on the forensic team have a more specialized *role*, and forensic nurses have the more global role (Q5-P05)

*New Emerging/expanded role.* As an emerging specialty, the term *forensic* has expanded to include nurses working with both victims and perpetrators in a variety of settings (Gudgeon, 2004).

- Some kind of framework for the analysis of our nursing *role*, I think is important cause when new roles are emerging, you need to constantly be looking at them and saying is it nursing just because a nurse is doing it, or are there other things that must be incorporated for it to be nursing, and then of course those options, *roles*, socialization, and competency. (Q2-P10)
- What became different in expanding the *role*, was not having physicians involved cause that's really one of the issues that started this. (Q6-P12)
- With the rising media awareness, the rising...violence. I believe that there's more support for the creation of positions, and the *role* of nurses. In there, as well as the *role* of nurse practitioners developing. (Q12-P02)

*Consultant/evolving role.* The evolving *role* of the forensic community mental health nurse (FCMHN) was a consulting *role*. The FCMHNs were often asked to offer independent advice and recommendations regarding care and management of forensic psychiatric patients. These recommendations formed the basis of the forensic clinical team's plan for treatment and management in the community (Friel & Chaloner, 1996). One example in the data was:

- I see forensic nursing, forensic mental health nursing, having a real *role* in primary prevention and in community collaboration early you know in the, sort of the whole scheme of things. (Q5-P01).

*Not exclusively a nursing role.* "In the initial coalescing period, the specialty may not be seen as exclusively a nursing role" (Hanson & Hamric, 2003, p. 203). In the past, some forensic roles were performed only by the physician and the nurse was often the handmaiden to the physician. An example in forensic nursing is the *role* of the nurse as a death investigator and the sexual assault examiner.

- This whole forensic *role* was something typically assigned to a physician, because they assumed it required a physician with not any basis for it. (Q9-P12)
- As originally being the handmaiden *role* to the physician, it wasn't our place to make diagnoses and so why include it in the curriculum. Now nursing diagnosis is included because of the legalities involved with professionalism, and to be a professional nurse and not have any knowledge about the importance of forensic concepts and, investigation would place the nurse in jeopardy. (Q12-P05)

### *Constructed Connotations of Forensic Nursing Role Theme*

With the expanded *role* of the sexual assault nurse examiner what became different was that the physician *role* was no longer included on the forensic team. However, the physician is included in the SART (Sexual Assault Response Team) model.

- ❖ When one subspecialty of forensic nursing (sexual assault nurse examiners SANE) expanded their *role*, what became different was the *role* of the physician was no longer involved in providing the sexual assault examination. In the case of another model - the Sexual Assault Response Team SART, however, the physician is still involved.

### *Typology 5.1M. Forensic Nursing Subspecialties*

Forensic nursing as a specialty of nursing has *subspecialties* that practice forensic nursing in different areas. The names of the *subspecialties* of forensic nursing for the most part have followed the name of the populations they care for: victims, perpetrators, living, and deceased (See Table 5.1M. Typology: Forensic Nursing Subspecialties Theme).

### *Literature Comparisons to Forensic Nursing Subspecialties Theme*

The forensic nursing *subspecialties* may include but are not limited to: forensic nurse examiner, sexual assault nurse examiner, death investigator, coroner, corrections nurse, forensic psychiatry nurse, and legal nurse consultant (IAFN, 2006).

Table 5.1M.

*Typology: Forensic Nursing Subspecialties Theme (11)**Data Extracts*

- 
- Clinical Forensic Nurse. (Q 2-P11)
  - Forensic Correctional Nurse. (Q6-P10)
  - Forensic Interpersonal Violence Nurse. (Q11-P16)
  - Forensic Legal Nurse Consultant. (Q8-P06)
  - Forensic Mental Health Nurse. (Q5-P01)
  - Forensic Nurse Educator. (Q2-P16), (Q11-P12), (Q13-P06), (Q11-P19)
  - Forensic Nurse Consultant. (Q8-P06)
  - Forensic Nurse Investigator. (Q2-P16)
  - Forensic Nurse Examiner. (SANE) (Q11-P09, Q11-P05, Q11-P12, Q11-P16, Q11-P19, Q11-P20)
  - Forensic Nurse Researcher. (Q6-P20)
  - Forensic Psychiatric Nurse. (Q6-P10)
- 

Examples of data extracts were:

- It's the breadth of the role that is so great: *legal nurse consulting, death investigation* as sub-specialty specialty areas under the domain or specialty of forensic nursing. (Q8-P06)
- *Clinical forensic nursing* involves primarily living patients who are either offenders or who are victims or individuals who vicariously are associated with the legal events that occurs in a health care setting. (Q2-P1)

*Forensic nurse investigator/examiner.* "In the initial coalescing period, the specialty may not be seen as exclusively a nursing role" (Hanson & Hamric, 2003, p. 203). An example in forensic nursing is the role of the nurse as a *death investigator* and *sexual assault examiner*. Examples in the data were:

- I have never personally worked as a *death investigator*, but there are numerous forensic nurses who, who have done that. (Q2-P16)

- I think seeing where the *forensic nursing sexual assault nurse examiners* here anyway are much more readily accepted here in the court system as experts, which prior to the SANE program we actually weren't. (Q8-P12)

*Forensic psychiatric/correctional nursing.* As an emerging specialty, the role of the forensic psychiatric nurse is not yet universal, and the term forensic has expanded to include nurses working with both victims and perpetrators in a variety of settings (Gudgeon, 2004). Correctional nursing became a recognized specialty of nursing (ANA, 1984) long before the broader specialty of forensic nursing was recognized. Examples in the data were:

- *Forensic psychiatric/ mental health and correctional nursing* is providing care to mentally ill offenders and to the incarcerated population and that is where the law component comes in to play. (Q1-P01)
- There were some initial articles out there on *correctional nursing*, and *forensic psychiatric nursing*, but whatever I could find out there mostly focused around *correctional nursing* and what I heard happening. (Q6-P10)

#### *Constructed Connotations of Forensic Nursing Subspecialties Theme*

In constructing a definition of forensic nursing, the data provided definitions of some of the *subspecialties* of forensic nursing. Examples from the data were:

- ❖ *Clinical forensic nursing* involves primarily living patients who are either offenders or who are victims or individuals who vicariously are associated with the legal events that occur in a health care setting.
- ❖ *Forensic psychiatric/correctional nursing* is really providing care to mental ill offenders and to the incarcerated population within the criminal justice system.

The *subspecialties* of forensic nursing contain within each one unique concepts.

The forensic nursing sub-specialties has relevant to the following themes:

- ❖ Knowledge Concepts to Include Theme.
- ❖ Knowledge Definition Theme.

*Theme 5.1N: Forensic Disciplines*

It is important that the roles and focuses of the different *disciplines* be demarcated. This has relevance when determining the core curriculum of specialty education and with the current and future trend toward interprofessional education (See Table 5.1N. Typology: Forensic Disciplines Demarcated).

Table 5.1N.

*Typology: Forensic Disciplines Demarcated*

<i>Nursing</i>	<i>Medicine</i>	<i>Law</i>	<i>Police</i>	<i>Criminology</i>	<i>Victimology</i>
<i>Focus:</i> Care/Caring coordinate health focused holistic comprehensive health promotion disease/illness prevention human responses to health /illness	<i>Focus:</i> Cure Healing Diagnosis disease focus illness focused disease /illness prevention and promotion	<i>Focus:</i> Justice Control Legal focus Regulation of human behavior	<i>Focus:</i> Law Enforcement Protection of citizens <i>Population:</i> Citizens Offenders	<i>Focus:</i> Security Custody and Control Security focus Custody of incarcerated humans <i>Population</i> Offender focus	<i>Focus:</i> Victim focus Advocate <i>Population</i> Victim focus
<i>Clinical Forensic Medicine</i>	<i>Forensic Medicine</i>	<i>Forensic Science</i>	<i>Forensic Social Work</i>	<i>Forensic Psychiatry/ Psychology</i>	<i>Forensic Nursing</i>
<i>Focus:</i> Trauma injury <i>Population</i> <i>Served:</i> Living patients Victims	<i>Focus:</i> Pathology Autopsy Disease/ illness focused Injury Prevention <i>Population</i> <i>Served:</i> Deceased	<i>Focus:</i> Discovery Collection of evidence Chain of Custody <i>Population</i> <i>Served:</i> Laboratory	<i>Focus:</i> Understand- ing Life story <i>Population</i> <i>Served:</i> Offenders/ Perpetrators	<i>Focus:</i> Forensic mental illness <i>Assessment:</i> Fitness / Competency Understanding of criminal behavior <i>Population</i> <i>Served:</i> Offenders/	<i>Focus:</i> Care and Custody Care and Collection of Evidence Care and Court Testimony Care and Chain of Custody Care and Community Safety Care and Health Promotion Care and Injury Prevention <i>Population Served</i> Victims /Offenders/ Deceased at Clinical Legal Interface

Table 5.1N. (cont.)

*Forensic Theme. Forensic Disciplines Demarcated*

<i>Forensic Sexual Assault Nurse Examiner (SANE)</i>	<i>Forensic Psychiatric/ Correctional Nursing</i>	<i>Nurse Death Investigator</i>	<i>Clinical Forensic Interpersonal Violence</i>
<i>Focus:</i> Care and Collection of Evidence Care and Court Testimony Care and Chain of Custody <i>Population Served:</i> Sexual assault survivors	<i>Focus:</i> Care and Custody <i>Population Served:</i> Offenders	<i>Focus:</i> Care and Custody of Body in Death Body as a crime scene <i>Population Served:</i> Deceased & Family	<i>Focus:</i> Care and Community Safety Injury and impact of injury on the victims <i>Population Served:</i> Victims
<i>Forensic Science (Physiology)</i>		<i>Forensic Behavioral Sciences (Social)</i>	
Forensic Medicine  Forensic Nurse Examiners (Sexual assault) Forensic Nurse Investigators (Death)		Forensic Psychiatry Forensic Psychology / Forensic Social Work Forensic Psychiatric Nursing Forensic Correctional/Prison Nursing	
Forensic Nursing			

*Literature Comparisons to Forensic Disciplines Theme*

A *discipline* is defined as an area of study (Merriam-Webster Online, 2003) and is distinguished by a domain of inquiry that represents a shared belief among its members regarding its reason for being. “A discipline can be identified by a focus statement in the form of a simple sentence that specifies the area of study” (Newman, et al., 1991, p. 1). A few examples of forensic *disciplines* present in the data were:

- No one *discipline* and no one sector in society can solve the problems that the forensic client presents with. It involves the justice system, the educational system, and the health care system, just to mention a few. (Q5-P01)
- But when you’re in the mental health domain, nurses run groups, nurses are doing counseling, others *disciplines* are doing the same kinds of

things, so those differences are a bit more blurry in some of those areas. (Q5-P01)

- It is not going to be constrained to only one *discipline*- -this practice is a multidisciplinary practice model that requires liaisons with law enforcement/medicine/the criminal and civil systems as well as colleagues such as IAFN. A broad base of knowledge is essential. (Q5-P03)
- And, previously, the court room had been relegated to physicians only, or primarily. I suppose some nurses were called to testify, but nursing was not considered a *discipline* of the forensic sciences, like medicine was. Forensic medicine was considered a *discipline* of the forensic sciences, but nursing was not. (Q5-P08)
- They don't really say what the *discipline* background of some of these people that work on CSI are, but you know they're not nurses. So, the media has not promoted it well. (Q11-P05)

*Discipline differences.* Core to the philosophy of the *discipline* of nursing is the philosophy of caring, where care versus cure has long been the discourse in differing approaches between nursing and medicine (Kent-Wilkinson, 1999b). Throughout the database of qualitative responses there was some mention of what nursing was and what medicine was and the distinguishing features between the two. One example present in the data was:

- Unlike medicine which is disease focus, nursing is health focused and comprehensive. (Q1-P19)

*Caring discipline.* "Knowledge about health that does not include caring would be knowledge of a discipline of health" (Newman, et al., 1991, p. 3). Nursing theories would link health to the human health experience. One example present in the data was:

- Although I do recognize that nursing isn't the only *discipline* that calls itself a caring *discipline*. But I mean that has been our contribution in many regards. But it's unique. (Q5-P01)

*Nursing's social mandate.* Those who specify nursing as a professional *discipline* emphasize that nursing has a "social mandate to develop, disseminate and use knowledge.



In contrast academic disciplines such as physics, physiology, sociology, psychology and philosophy are mandated only to develop and disseminate knowledge” (Fawcett, as cited in Barrett, 2002, p. 55).

*Clinical setting more likely.* Nursing is a practice *discipline*, therefore, knowledge development is key at the clinical practice interface. An example from the data was:

- I think most of the other forensic science operate in a pretty laboratory like environment for the most part and are fairly well confined most of the time, whereas forensic nurses are in the clinical setting. (Q5-P11)

*Nursing as a profession, an academic discipline and a science.* Holzemer (2007) reminded us that nursing is a profession, an academic discipline, and a science. More comfortable may be the idea of nursing as a practice profession that is recognized by the public and often defined by legal statutes. Nurses who practice have ethical, legal, and clinical responsibilities to care for their patients, clients, and families. Society grants the nursing profession certain rights and privileges that create significant trust by the public in nursing. Examples from the data were:

- I think society’s acceptance of the nurse...And particularly that it’s the most trusted profession in the U.S., from a survey in the US. (Q11-P19)
- Macleans did a survey across Canada that I just recently pulled...it was that nurses are the second or third most trusted *discipline* ...far above police officers, doctors, lawyers, you name it? And I think firefighters were the number one. (Q11-P09)

#### *Constructed Connotations of Forensic Disciplines Theme*

The forensic specialty is not constrained to only one *discipline*. An example of a constructed finding from the data was:

- ❖ No one *discipline* and no one sector in society can solve the problems that the forensic client presents with. It involves multiple *disciplines* working together.

Many health care *disciplines* have multiple specialties or focus areas, but the licensing body, social mandate, philosophy, and core values adhere to the main regulating discipline. Each *discipline* has a professional licensing body with a body of knowledge. Specialty areas of each *discipline* have their own unique body of knowledge and unique focus, but they are not a *discipline* of their own, in that they are not separate from their professional regulatory body.

- ❖ And when nursing is the licensed profession or discipline, it's the health and legal that pulls nursing into it. Because unlike medicine which is disease focus, nursing is health focused and comprehensive.
- ❖ Forensic nursing is a specialty of the *discipline* of nursing at the clinical legal interface where care is provided to victims, offenders, living and deceased.

#### *Theme 5.10 Forensic Multidisciplinary*

The importance of collaborative *multidisciplinary* team relationships and the fact that forensic nurses often work in a *multidisciplinary* context was evident throughout the data set. Some of the responses made compelling arguments for a *multidisciplinary* practice model (See Table 5.10. Typology: Forensic Multidisciplinary).

Table 5.10.

#### *Typology: Forensic Multidisciplinary theme*

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##### *Topics*

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- Multidisciplinary
  - Interdisciplinary
  - Intersectoral
  - Importance of the Team
  - Nursing's Contribution to the Team
-

### *Literature Comparisons to Forensic Multidisciplinary Theme*

Brooker and Whyte (2000) in a report aimed at multidisciplinary team-working in secure psychiatric settings argued that interprofessional training should take place at the clinical interface. They also added that it should focus on client-centered, problem-based learning exercises that allow for reflexive learning.

*Forensic multidisciplinary training.* Mason and Carton (2002) reported on their research undertaken to identify if common areas of multidisciplinary training in forensic mental health practice existed by doing a review of literature and curriculum documents. An important finding of that review was that process was just as important as content in the care/ management of mentally-disordered offenders. The process was assisted by a knowledge base that was related to forensic practice and constructed from 13 broad multidisciplinary training areas: legal, assessment, treatment, evaluative, research, management, multidisciplinary, service development, risk, forensic, other, security, and ethical issues. Their model provided evidence to support common areas of *multidisciplinary* forensic training that specific training were required for staff to take action in these 13 areas (Mason & Carton). “In order for this new branch of nursing to grow, it must by necessity, outline its knowledge base, and identify its core skills and locate the realms of forensic nursing set within a multidisciplinary context” (p. 551).

Examples of data extracts from this study were:

- It’s predominantly nursing but, the philosophy that we have is that nurses work within a *multidisciplinary* context. And we have to understand the role of the other professions that are coming into that context and they have to understand the role that we have. (Q2-P02)

- The courses are best conceptualized as *multidisciplinary* conceptualization, with forensic teams. We also need to know each other's roles. (Q2-P09)
- That *multidisciplinary* understanding. So it's predominantly aimed at nurses but, we do allow other professions to take the courses. (Q2-P02)
- I agree nursing is that foundational base. It's sort of the synthesis of many disciplines. (Q3-P07)
- Philosophically we believe that it's a very *multidisciplinary* collaborative program. That's very important for us. Even though nursing of course is, it's our core. We want the students to be very knowledgeable so that they do represent forensic nursing well. (Q3-P17)
- It is not going to be constrained to only one discipline- - this practice is a *multidisciplinary* practice model that requires liaisons with law enforcement/medicine/the criminal and civil systems as well as colleagues such as IAFN. A broad base of knowledge is essential. (Q5-P03)

*Forensic multidisciplinary team.* Baxter (2002) in his study noted that the nursing role was perceived as being complementary to that of other disciplines. Nurses were viewed as making a unique contribution to the multidisciplinary team. Although coinciding with psychiatry, psychology, and clinical criminology in some respects, this nursing discipline was nonetheless distinct (Brooker & Whyte, 2000). Examples from the data were:

- Understanding the role of the different professionals. Could be the police or the investigation of the Crown attorney, or who-ever. The role of defense, our content, for example, does not deal a lot in, because its specific to, it's not a general forensic nursing course, it's a specific skills and knowledge that a sexual assault nurse examiner needs to have. (Q2-P12)
- And one of the things that I think is really important is caring for both the forensic needs of the patient and the clinical psychological needs of the patient; also the importance of working as a team, and understanding the roles of other team members. (Q6-P20)
- A major objective of ours was to get nurses to broaden their perspective of their practice to understand that, when they are working with police officers they're not in an adverse position with them, when dealing with the client. That they are collaborative professionals trying to help this particular victim or perpetrator. (Q3-P17)

*Forensic nursing's contribution to the multidisciplinary team.* Robinson and Kettles (1998) found that forensic nursing's contribution to the multidisciplinary team was in the provision of a balanced, holistic view of the individual and ward collective impact. Forensic nurses provided a link between other disciplines which was a pivotal role and central to communication. As well as being coordinators of care, forensic nurses provided support for the patient and explained situations to the offender in a simple language. They also coordinated the therapeutic activities for patients. Forensic nurses "educated other disciplines about nursing, i.e., that nurses worked to a professional code of conduct, however this code was not specific to the forensic specialty" (p. 217).

*Forensic nursing's challenges with the multidisciplinary team.* With regard to difficulties with the multidisciplinary team, forensic psychiatric nurses according to Robinson and Kettles (1998) felt they had less influence, although they felt they contributed to the team, less status reflected in less pay, and less autonomy than other disciplines. Forensic nurses felt they had difficulty contributing to the team, in that they saw themselves as lacking in professional credibility as specialty nurses, however this point varied. Forensic nurses felt that it was "not an exchange of equals, because nursing staff felt manipulated by other professional. They felt they were still seen as 'handmaidens', although they were more willing than other disciplines, to take risks, some forensic nurses felt underused" (p. 217).

#### *Constructed Connotations of Multidisciplinary Theme*

A multidisciplinary practice model requires liaisons with law enforcement, medicine, the criminal and civil legal systems, and colleagues from other forensic

disciplines. A constructivist approach is a collaborative approach where disciplines are working with each other and not against. Examples from the data of constructed statements with regard to the need for a *multidisciplinary* approach are:

- ❖ It is important that both the forensic needs of the patient and the clinical psychological needs of the patient are met by team members.
- ❖ Important to forensic nursing is working as a team and understanding the roles of other team members.
- ❖ A major objective of forensic nursing is to work with other disciplines, not in an adverse position with them, when dealing with the client. The forensic team is a collaborative group of professionals trying to help each particular victim or perpetrator.

#### *Theme 5.1P. Forensic Models/Frameworks*

Throughout the dataset, the participants indicated *models* and *frameworks* that they used or suggested *models* and *frameworks* that should or could be used for forensic nursing (See Table 5.1P. Typology: Forensic Models/Frameworks). Participants generally stated that a theoretical *framework* was necessary for forensic nursing education.

Table 5.1P.

#### *Typology: Forensic Models/Frameworks)*

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n=7 Frameworks and Models

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|--|--|
| <ul style="list-style-type: none"> <li>• advanced practice forensic nursing model</li> <li>• expanded nursing practice model</li> <li>• multidisciplinary practice model</li> <li>• nursing framework with forensic science extension</li> <li>• population health model</li> <li>• public health model</li> <li>• WHEEL (wounding, healing, evidence, ethics, legal)</li> </ul> | <ul style="list-style-type: none"> <li>• (forensic) nursing process (theoretical practice model)</li> <li>• (forensic) nursing paradigm</li> </ul> |
|--|--|
-

### *Literature Comparison of Forensic Models/Frameworks to this Study*

*Advanced practice nursing/advanced nursing practice.* As nurses move along the continuum of experience and education, they acquire additional competencies that are incorporated into their practice. This enables nurses to contribute to the health care system in new ways. One career pathway, nurses choose is advanced nursing practice (CNA, 2002a).

Advanced Nursing Practice involves integration of knowledge from other disciplines into the practice of nursing; it requires a depth and breadth of knowledge that enables the nurse to provide an ever-increasing range of strategies to meet the complex needs of clients; it includes the ability to explain the theoretical, empirical, ethical and experiential foundations of nursing practice; and it contributes to the understanding and development of evidence-based nursing knowledge through involvement in research and the evaluation and utilization of relevant research findings (CNA, 2002b, ¶ 5).

Some examples from the data of this study were:

- It's unique in that forensic nurses, the advanced practice forensic nurse is definitely prepared with a broader background, in order to be able to collaborate with all the people, with all the professionals that are pertinent to any particular victim or perpetrator. (Q5-P17)
- Unique to forensic nursing is an understanding of the theories of violence, and understanding psychological theories of why people do what they do. Why do people stay in abusive situations and why do people cause abusive situations? We touch on that sometimes in undergrad nursing, but we haven't done a lot with that. So I think that why forensic...the advanced practice forensic nurse is going to make a big difference. (Q5-P17)

*Population health framework/module.* Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities

among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on health (Public Health Agency of Canada, 2002). A population health approach takes action based on analyses and understandings of the entire range of the determinants of health. A population health approach recognizes the complex interplay between the determinants of health. It uses a variety of strategies and settings to act on the health determinants in partnership with sectors outside the traditional health system or sector (Public Health Agency of Canada). Examples from the data were:

- Our *conceptual framework* is based on holistic nursing and the concept of population health. (Q2-P07)
- Population health, we see as the care of aggregates and an aggregate being any group that has one common characteristic. And that, if you can concentrate on improving, you can identify the concerns. (Q2-P07)

*Public health framework/module.* A public health approach embodies a systems perspective, containing the continuum of prevention and control, from determinants to care. In this framework it is critical to identify and address interactions and interventions that connect between and among the three levels of action (Robes, 2004), primary prevention, secondary prevention, and tertiary prevention. The Centre of Disease Control (CDC's) National Center for Injury Prevention and Control's public health model approach to injury research and practice allows the researcher to progress towards the goal of reducing injuries by moving through the following stages: Defining the problem; identifying risk and protective factors; developing and testing prevention strategies; and, assuring widespread adoption (John Hopkins Bloomberg, School of Public Health, 2007). Examples from the data were:



- Forensic nursing is from the aspects of trauma or injury to the victim and also to help to prevent injury as well as education for the public for the individual perpetrator or for the victim through counseling and the interfacing of all the different branches of the legal system. (Q1-P05)
- Forensic nursing is understanding the public health component, the capacity to prevent, in the work that we have to do at a policy level. (Q1-P19)
- Forensic nursing is a way to improve services for victims, ensure that their needs are met, and a way to reduce crime by holding criminals or assailants accountable. (Q1-P20)
- The unique knowledge of forensic nurse is being able to bring all of ones basic nursing skills to work with a patient population that has medical, nursing, social and legal piece so what you are bringing is all the things that we learn in practice of nursing but also an understanding of the importance of evidence collection, evidence preservation, interviewing, accuracy, history taking, all of that to prevent re-occurrence or from the abuse reoccurring. You are kind of blending it more into a public health framework. (Q5-P16)

*Multidisciplinary practice model.* Defining *models* is invariably a difficult and complex task. The reduction of complex, multidisciplinary practice into a unified practice model is far from straightforward. Team members from differing professional backgrounds hold a range of beliefs about current health care practice. Client groups have become increasingly powerful in shaping service *models*. The perspectives of managers and planners may differ further still. “The involvement of practitioners in producing a set of categories to define practice is essential, and their commitment and cooperation are vital if a workable set of practice categories is to be produced and data collected”

(Fiander & Burns, 2000, p. 656). Examples from the data were:

- It is not going to be constrained to only one discipline –this practice is a multidisciplinary practice *model* that requires liaisons with law enforcement/medicine/the criminal and civil systems as well as colleagues such as IAFN. A broad base of knowledge is essential. (Q5-P03)
- No it’s predominantly nursing but, the philosophy what we have is that nurses work within a multidisciplinary context. And we have to

understand the role of the other professions that are coming into that context and they have to understand the role that we have. (Q2-P02)

- The courses are best conceptualized as multidisciplinary conceptualization, with forensic teams. We also need to know each other's roles. (Q2-P09)
- That multidisciplinary understanding. So it's predominantly aimed at nurses but, we do allow other professions to take the courses. (Q2-P02)
- Nursing is the foundational base. It's sort of the synthesis of many disciplines. (Q3-P07)
- Philosophically we believe that it's a very multidisciplinary collaborative program. That's very important for us. Even though nursing of course is, it's our core. To be very knowledgeable so that they do represent forensic nursing well. (Q3-P17)

*Interprofessional educational/practice model.* With the trend to interdisciplinary education, *forensic health care* is an area that is well suited for interdisciplinary education. Examples from the data were:

- And intersectoral collaboration in particular. (Q5-P01]
- I think it's a real area where intersectoral and interdisciplinary collaboration is critical. (Q5-P01)
- Most satisfying in teaching forensic nursing is when students recognized the need for multisectoral or intersectoral collaboration and seek out ways to enhance their care. (Q8-P01)

An *Interprofessional Educational Practice model* was constructed from the data of this study:

- ❖ Forensic nursing is an area where intersectoral and interdisciplinary collaboration is critical. The forensic specialty is not constrained to only one discipline. No one discipline and no one sector in society can solve the unique and complex problems that the forensic client presents with. Intersectoral approaches that bring together justice, law, social services, education, and health care are deemed necessary to address the complexity of issues facing the forensic client. An interprofessional or multidisciplinary practice model requires liaisons between and among not only nursing, law enforcement and criminal justice, but also colleagues from other forensic disciplines such as forensic science, forensic medicine and forensic psychiatry throughout the criminal and civil legal systems, and/or the medical examiner or coroner systems. The forensic team is a

collaborative group of professionals with the mutual goal to help each particular victim or perpetrator. A major objective of forensic nursing is to understand the roles of other disciplines on the team and to work with other disciplines, not in an adverse position with them, when dealing with the client. The collaborative nature of forensic nursing practice is a significant component of the forensic multidisciplinary team.

*Other models/frameworks.* The participants introduced numerous other *frameworks* and *models* through their development and teaching of forensic nursing educational courses, as forensic nursing roles and concepts were new possibilities to many nurses. Other examples in the data were:

*Expanded Nursing Practice Model.*

- What are the resources that are available, when developing a program that is introducing an expanded nursing practice *model*? (Q5-P03)
- And then I saw the need to expand, really the base of nursing knowledge to include victimology, and that's how I did it. (Q5-P03)

*Nursing Framework with Forensic Science Extension*

- We wanted to ensure, that we were preparing nurses, to operate from a framework where forensic science was a natural extending part of the nursing process. It was the responsibility, philosophically, of forensic nurses as a servant of society. (Q3-P11)

*Framework Needed for the Analysis of New Nursing Roles*

- Some kind of *framework* for the analysis of our nursing role, I think is important cause when new roles are emerging, you need to constantly be looking at them and saying is it nursing just because a nurse is doing it, or are there other things that must be incorporated for it to be nursing, and then of course those options, roles, socialization, and competency. (Q2-P10)
- I always start from an analysis of what I think nurses need to know in order to implement new roles, which would include things like: historical overview of emerging roles. (Q2-P10)
- I'm really housed in role theory, from my basic doctoral education, and I feel very strongly that if we don't have a real understanding of how nursing roles have emerged, and for the most part, without a whole lot of our input and our regulation and our control. (Q2-P10)

*WHEEL*

- But these (The Wheel: wounding, healing, evidence, ethic, and legal) to me are the core concepts that are different from our nursing in general but

use the same theoretical underpinnings, which is person, environment, health and nursing. (Q5-P19)

- Wounding, healing, ethics, evidence and legal, and then public health and the acronym is *wheel*. You see I need to write that up. I started talking about the wheel back in, in the middle '90's. (Q5-P19)
- Well for me it was the *wheel*. The wounding and healing. We found out about disease in nursing school, but we never found out about injury. Injury that was intentional, and non-intentional, but with some criminal intent. Oh the wounding and the healing. Not criminal intent but certainly intent that was held accountable. (Q5-P19)

#### *Generalist/ Specialist Program*

- Our program is what I refer to as a forensic nursing *generalist* program. (Q2-P06)
- So it incorporates content areas specific to the forensic sciences, forensic chemistry we also have a course on forensic toxicology, and a death investigation medical examiner's course. And a crime scene and evidence course that really fits more in, in, kind of that *generalist* track, that *generalist* domain of practice. (Q2-P06)
- The education does focus in all those areas, but they don't, they can focus in on their own one area that they want to practice, but they have to have an understanding of all the areas. (Q2-P17)
- Some programs feel students should be prepared as a SANE, as a death investigator, as a legal nurse consultant, or at least gone through all those courses. We don't do that and, and our goal, is more for the person to get a broad understanding of all of those. (Q2-P17)

#### *Nursing Process*

See Typology 5.1Q (Forensic) Nursing Process (Pentalogy)

#### *Nursing Paradigm*

See Typology 5.1R. (Forensic) Nursing Paradigm (Tetralogy)

#### *Constructed Connotations of Forensic Models/Frameworks*

Throughout the database, different *frameworks* or *models* were mentioned by the participants as to approaches that from their perspective would be an applicable *framework* or *model* for forensic nursing. Each of the *models* and *frameworks* cited individually, and in combination have been applied to forensic nursing and have been

effective frameworks. In addition, the nursing paradigm and the nursing process as described in a separate section in this chapter would be applicable.

*Typology: 5.1Q. Forensic Nursing Process (Pentalogy)*

The *nursing process* has been widely identified as the five steps of assessment, diagnosis, planning, intervention, and evaluation. The *nursing process* is based on a nursing theory developed by Ida Jean Orlando in the 1950s. Orlando developed this theory by observing nurses in action. From observations Orlando learned: the patient must be the central character; nursing care needs to be directed at improving outcomes for the patient, not about nursing goals; and, the nursing process is an essential part of the nursing care plan (Orlando, 1972). The *nursing process* is comparable to many other processes relevant to forensic nursing (See Table 5.1Q. Pentalogy: [Forensic] Nursing Process).

*Literature Comparisons of the Forensic Nursing Process Pentalogy*

The theoretical practice model of forensic nursing is based on the integration of forensic science, criminal justice, and nursing science in a unique application of the nursing process to legal proceedings (Bell & Benak, 2001). Forensic nursing implements the *nursing process* and elements of other processes, such as the scientific process, and the legal process.

Table 5.1Q.

*Typology: (Forensic) Nursing Process (Pentalogy)*

<i>The Nursing Process</i>		<i>Legal Process</i>	
<i>(Theoretical Practice Model) Nursing process</i>		<i>Legal Process</i>	
<ul style="list-style-type: none"> <li>• Assessment (of patient's needs)</li> <li>• Diagnosis (of human response needs that nursing can assist with)</li> <li>• Planning (of patient's care)</li> <li>• Implementation (of care)</li> <li>• Evaluation (of the success of the implemented care) (Ida Jean Orlando, 1950s )</li> </ul>		<ul style="list-style-type: none"> <li>• Discovery</li> <li>• Evidence</li> <li>• Decisions of prosecution (Neubauer, 1979).</li> </ul>	
<i>(Forensic) Nursing Process</i>		<i>Legal Process</i>	
<ul style="list-style-type: none"> <li>❖ Forensic Nursing Assessment</li> <li>❖ Forensic Nursing Diagnosis</li> <li>❖ Forensic Nursing Planning</li> <li>❖ Forensic Nursing Implementation</li> <li>❖ Forensic Nursing Evaluations</li> </ul>		<ul style="list-style-type: none"> <li>• First Appearance</li> <li>• Omnibus Hearing</li> <li>• Pre-Trial Hearing</li> <li>• Trial</li> <li>• Sentencing</li> <li>• Restitution</li> </ul>	
<i>Scientific Process</i>	<i>Scientific Method</i>	<i>Criminal Process</i>	<i>Political Process</i>
<ul style="list-style-type: none"> <li>• Identify the problem or question.</li> <li>• Develop a hypothesis.</li> <li>• Test the hypothesis.</li> <li>• Evaluate the data</li> <li>• Identify a new problem</li> </ul>	<ul style="list-style-type: none"> <li>• Observe</li> <li>• Research</li> <li>• Hypothesize</li> <li>• Test</li> <li>• Conclude</li> <li>• (Wilson, 1952)</li> </ul>	<ul style="list-style-type: none"> <li>• Reporting</li> <li>• Investigating</li> <li>• Charging</li> <li>• Prosecuting</li> <li>• Sentencing</li> <li>• Serving</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement in decision making</li> <li>• Analyze and influence health policy</li> </ul>

*Scientific process/legal process.* The *scientific process* according to Wilson (1952) is the five step process of observe, research, hypothesize, test and conclude. The *legal process* consists of discovery, evidence, and decisions of prosecution; or first appearance, hearing, trial, sentencing and restitution (Neubauer, 1979). In the data extracts, the nursing process was compared or applied to the specialty of forensic nursing by including the steps of the scientific process and the legal process and the political process.

Examples of data extracts were:

- Forensic nursing is a combination of the *nursing process*, and the *scientific process*. (Q5-P11)
- As far as the *legal process*, you have discovery, you have evidence you have to go through. It's the same process only a different issue. (Q2-P07)

In addition, forensic nurse leaders have made the decision to be involved in the *political process* or policy decision making with regard to the issues relating to the forensic nursing specialty.

*Nursing process.* The *nursing process* is a process by which nurses deliver care to patients. It is often supported by nursing models or philosophies. The nursing process was originally an adapted form of problem-solving and is classified as a deductive theory (Wikipedia, 2007g). Forensic nursing is a unique application of the nursing process to legal proceedings (Bell & Benak, 2001).

- Forensic nursing is a combination of the *nursing process* and the *scientific process*. (Q5-P11)
- Forensic nursing is integral to the assessment, planning and outcome effectiveness of the nursing care plan that we really needed from the beginning of nursing education. (Q1-P03)
- We looked at the *nursing process*, and what might change in that. (Q2-P10)
- We wanted to ensure, that we were preparing nurses, to operate from a framework that forensic science was a natural extending part of the *nursing process*. It was the responsibility, philosophically, of forensic nurses as a servant of society. (Q3-P11)
- And using the *nursing process*, the assessment phase, the analytical phase, and the problems solving, planning, you can really construct that together in a fairly nice loop. I think understanding, the principles of evidentiary collection and management is unique. (Q5-P11)
- The *nursing process* is used to evaluate what is best for the victim. Be able to analyze, and do the best for the victim, but it has to be in a realistic context to her. There's no point doing some of this, a vaginal swab on somebody if they, it didn't happen. (Q5-P12)
- The *nursing process* as applied to forensic nursing is when nurses make an evaluation based on the assessment. (Q11-P09)

### *Constructed Connotations to Forensic Nursing Process Pentalogy*

Forensic nursing is the application of not only the *nursing process*, but also certain elements of the *legal process*, the *political process*, and the *scientific process*. Based on the nursing process which is a deductive theory, the *forensic nursing process* consists of the following:

#### *Forensic Nursing Process (Constructed)*

- ❖ The principles of forensic nursing are an integral part of the nursing process. Forensic nursing is a combination of not only the *nursing process*, but also elements of the *scientific process*, the *legal process*, and even the *political process*. Forensic nursing is vital to the assessment, planning and outcome effectiveness of the nursing care plan.
- ❖ The forensic nurse uses the *nursing process*: the nursing assessment, nursing diagnosis, nursing planning, nursing intervention and nursing evaluation.
- ❖ The *nursing process* can guide care for specialized forensic patient populations and can be applied to public or legal proceedings.

#### *Forensic Nursing Assessment*

- ❖ Risk assessment, sexual assault assessment and examination, evidence collection, history taking physical assessment, documentation, the injuries, taking photographs, mental status, identification injury, various screenings, fitness and competency assessments.

#### *Forensic Nursing Diagnosis*

- ❖ (diagnosis of human response needs that nursing can assist with) analytical phase, analysis of injury, trauma, emotional status, nurse practitioner role

#### *Forensic Nursing Planning*

- ❖ problem solving, planning of patient care

#### *Forensic Nursing Implementation*

- ❖ violence prevention, crisis intervention, primary, secondary, and tertiary levels of intervention, community treatment, community collaboration, court testimony

#### *Forensic Nursing Evaluations*

- ❖ outcome effectiveness

### *Typology 5.1R. Forensic Nursing Paradigm (Tetralogy)*

The central concepts of *nursing's paradigm* are the relationship of the person, client, health, environment, and nursing. Most participants stated that the philosophy of



their forensic nursing programs was the same as their general nursing programs. The *nursing paradigm* is the nursing philosophy cited by most colleges, schools, and departments of nursing at college and universities. The central concepts in the *nursing paradigm* may have unique elements specific to each specialty of nursing, but the basic central components remain stable: person/client, health, environment, and nursing (See Table 5.1R. Tetralogy: [Forensic] Nursing Paradigm).

*Literature Comparisons of the (Forensic) Nursing Paradigm Tetralogy*

The focus of nursing as a professional discipline has emerged most prominently over the past few decades. A number of concepts have been identified as central to the study of nursing. An example is the frequently cited tetralogy: person, environment, nursing, and health (Fawcett, 1984; Torres & Yura, as cited in Newman, et al., 1991).

Table 5.1R.

*Typology: (Forensic) Nursing Paradigm (Tetralogy)*

<i>Nursing Paradigm</i>	<i>Forensic Nursing Paradigm (constructed)</i>
<ul style="list-style-type: none"> <li>• person (individual)</li> <li>• environment</li> <li>• health</li> <li>• nursing</li> </ul>	<ul style="list-style-type: none"> <li>❖ Forensic populations (person, individuals, victims, offenders)</li> <li>❖ Forensic environment (ED's, correctional institutions)</li> <li>❖ Forensic health (abuse/neglect, injury/trauma)</li> <li>❖ Forensic nursing (SANE, forensic psych /correctional, clinical forensic, death investigators, ...)</li> </ul>

“Our philosophy of forensic nursing is constantly evolving. Yet it is an evolution that grows from the four central components of nursing’s metaparadigm: person, society, health and nursing” (Fawcett, 1984; Flaskeud & Halloran, 1980; Kent-Wilkinson, 1993, p.

23). How is the *nursing paradigm* applied to forensic nursing? Data extracts were identified with the central concepts of the *nursing paradigm* as follows:

- How we define the human being, environment, nursing, and health differently, or different words that we come across when we look at forensic, so we looked at the *nursing paradigm*. (Q2-P10)
- Because it (forensic nursing) truly encompasses person, environment, health and nursing, which is nursing!” (Q2-P19)
- That whole focus on everything I’m doing is not only meeting the needs of this immediate client, but have direct implications for possibly prosecution or the safety of the community, or the environment in which we are in, in terms of how we kind of articulate against what I believe is criminal justice or social constructs that have to do with what’s legal and what’s not. (Q5-P10)
- But these (The Wheel: wounding, healing, evidence, ethic, and legal) to me are the core concepts that are different from our nursing in general but use the same theoretical underpinnings, which is person, environment, health and nursing. (Q5-P19)

#### *Constructed Connotations to Forensic Nursing Paradigm Tetralogy*

The *paradigm of nursing* consists of four central constructs: person (individual), environment, health and nursing. Based on the *nursing paradigm* the forensic nursing paradigm consists of forensic person (victim or offender, deceased); forensic health (abuse, neglect, injury, trauma); forensic environment (criminal justice system, medical examiner system/coroner system, forensic mental health care system), and forensic nursing (all subspecialties e.g., SANE, forensic psychiatric/correctional, death nurse investigator etc.). A constructed statement is as follows:

- ❖ Forensic nursing truly encompasses the *nursing paradigm*, with its own unique definitions of person, health, environment and nursing.

#### *Theme 5.1S. Forensic Meta Theory, Social Justice*

One participant noted that “Justice is a thread that weaves through forensic courses.” There were also many references in the data that referred to *social concepts* and

*society*, in addition to what was previously addressed with regard to the legal prefix and the relationship of forensic nursing to the justice or legal system in Typology 5.1D and Typology 5.1E. (See Table 5.1S. Typology: Forensic Meta Theory, Social Justice).

Table 5.1S.

*Typology: Forensic Meta Theory, Social Justice*

<i>Justice</i>	<i>Social</i>
Justice. (Q3&4-P01)	Society. (Q5-P01)
Justice. (Q5-P06)	Social construct. (Q5-P10)
Justice. (Q1-P16)	Societal norms. (Q3&4-P01)
	Societal expectations. (Q3&4-P01)
	Social processes. (Q5-P11)
	Social service mission. (Q5-P11)

*Literature Comparison of Forensic Meta Theory Social Justice*

*Social justice* refers to the concept of a just society, where *justice* refers to more than just the administration of laws. It is based on the idea of a society that gives individuals and groups fair treatment and a just share of the benefits of society.

*Justice*. Different proponents of social justice have developed different interpretations of what constitutes *fair treatment* and a *just* share. It can also mean distribution of advantages and disadvantages within a society or community (Wikipedia, 2007f). Examples from the data on *justice* were:

- *Justice* is not a philosophy but certainly a thread that weaves through the course. (Q3-P01)
- *Justice* is equally important for the perpetrators of violent crime, or offenses, as it is for victims. (Q5-P06)
- Forensic nursing is where nurses work with patients, who have a high likelihood of interfacing with one of the *justice* systems, whether that be a civil justice system or a criminal *justice* system. (Q1-P16)

- So how does one care for someone who, in society's eyes is an offender; someone who should be locked up and never allowed out. How does caring translate into how nurses care about those individuals? And the other part of this is certainly what *justice* is- that everyone is entitled to *just* outcomes. (Q5-P06).

*Social/society.* Social justice provides the foundation for a healthy community. It grows out of the belief that each person, each created being, has value. A healthy community is built when the value and dignity of each person is recognized, but this process of learning is slow and painful. The process is helped by the development of attitudes of respect for one another. This process occurs in a society by building governmental and economic structures, educational and religious institutions, and all the other systems that provide for health and social welfare. This justice is not a goal that we'll ever reach, but a process, a struggle in which we can be engaged through all the pain and all the joy (Mayer, 2006).

There are a number of movements based on *social justice* that reflects the way in which human rights are manifested in the everyday lives of people at every level of society. These movements are working towards the realization of a world where all members of a society, regardless of background, have basic human rights and an equal opportunity to access the benefits of their society" (Mayer, 2006). Examples of data extracts that relate to *social/society* were:

- As forensic nurses we have a *social* sense of continuity, we have a sort of a need, or a responsibility for ensuring some sort of a therapeutic contact is maintained with the person, it may not be the forensic nurse, himself or herself doing this, but it's part of our responsibility to ensure that those *social* processes are fully integrated. (Q5-P11)
- *Societal* norms and *societal* expectations impact on how to care for vulnerable groups. (Q3-P01)

- And I think that the prison is a real reflection of the community at large for the problems that you see within a prison, or the problems that brought the person to prison or to the forensic hospital is a reflection of the problems within *society*. (Q5-P01)
- That whole focus on everything I'm doing is not only meeting the needs of this immediate client, but also have direct implications for possibly prosecution or the safety of the community, or the environment in which we are in, in terms of how we kind of articulate against what I believe is criminal justice or *social* constructs that have to do with what's legal and what's not. (Q5-P10)

### *Constructed Connotations of Forensic Meta Theory of Social Justice*

The practice of forensic nursing fits the basic principles of *social justice* which was simply defined as the concept of a *just society* and a healthy community. *Social justice* is an option that could be used as an overarching or meta framework or theory for forensic nursing and forensic nursing education, which could encompass many mid-range theories.

#### *Social Justice as a Meta Theory for Forensic Nursing Education (Constructed)*

- ❖ *Social justice* is a thread that weaves through forensic nursing and forensic nursing educational programs
- ❖ *Societal* norms and *societal* expectations have an impact on how care is provided for vulnerable groups.
- ❖ *Justice* is equally important for the perpetrators of violent crime, or offenses, as it is for victims.
- ❖ *Societal* norms influence the care and treatment of victims and offenders.
- ❖ The *social* determinants of health can positively and negatively influence the health of the forensic client (victim or offender).
- ❖ Intersectoral approaches that bring together *justice*, law, *social* services, education, and health care, are deemed necessary to address the complexity of issues facing the forensic client.

### Knowledge Themes of Forensic Nursing

The remaining knowledge themes are represented by the following titles:

#### *5.2. Knowledge Needed and Concepts to Include*

#### *5.3. Knowledge Differentiated*

#### 5.4. Knowledge Dual (Unique Knowledge)

#### 5.5. Knowledge Defined

#### *Theme 5.2. Knowledge Needed or Needed Concepts to Include*

In responding to the questions throughout the study of questions 1-13, the participants often stated what *knowledge* they thought was *needed* for forensic nursing and what specific concepts they thought were needed in the courses curriculums. Concepts were identified from the total data extracts of this study which also included concepts provided by the participants of the titles of their courses and module concepts offered at their institutions. The categories were divided into *Knowledge Needed* and *Knowledge Concepts to Include* (See Table 5.2a. Knowledge Needed Theme).

Table 5.2a.

#### *Theme: Knowledge Needed and Knowledge Concepts to Include*

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##### *Knowledge Needed*

- Needed Knowledge from other Disciplines. (Q5-P17), (Q6-P11)
- Needed Experiential Knowledge (Q1-P20), (Q6-P20)
- Needed Skills. (Q12-P05), (Q6-P11)
- Needed Knowledge of Theories. (Q5-P17)

##### *Knowledge Concepts to Include*

- Needed Concept to Include  
(See Taxonomy in Appendix D3)
- 

#### *Literature Comparisons to Knowledge Needed & Concepts to Include Theme*

The literature provided evidence of what *knowledge is needed* for the forensic specialty focus. In addition, advanced education provides academic preparation that is needed for all disciplines.

*Knowledge needed of law.* Nurses and other health professional need a much broader knowledge of criminal law, the Mental Health Act, the Public Hospital Act and the Child Services Act in order to answer questions more accurately and effectively (Naiman, 2006). One example from the data was:

- Many professionals don't know the law enough that applies to their practice, for example the Child Family Protection Act, the Infants Act, even the police don't know about the Infants Act. (Q5-P09)

*Need for educational preparation.* There is a need for education preparation of nurses as they are increasingly required to conduct formal assessments and produce comprehensive/influential clinical/managerial reports (Friel & Chaloner, 1996). One example from the data was:

- Part of me feels that nurses, actually forensic nurses, we *need* to know how to write. We *need* to be able to generate reports that follow coherent guidelines so that people who read our report know what we're talking about. (Q8-P16)

*Knowledge needed from other disciplines.* Participants often stated that forensic nursing was nursing that *need knowledge* from other disciplines. Examples of data extracts were:

- It's not just medical science, and nursing science, but it's also forensic science. (Q5-P17)
- Forensic science, forensic psych, criminology courses shaped forensic nursing. (Q6-P11)
- That's certainly a very large component is what I would consider behavioral sciences, forensic psychology, psychiatry. Where we look at not only the physiological effects of trauma on victims, but also the psychological consequences, and certainly one course completely focuses on perpetrator behavior. (Q2-P06)

*Knowledge needed to become a forensic nurse.* Students often asked: How do I become a forensic nurse? The following vignette or data extract provides three areas of

the knowledge needed in this process: knowledge from other disciplines, experiential knowledge, and skills required.

- I have been providing nursing care to patients for 30 years, often that involved taking care of sexually assaulted women. I provided good care but no one called me a forensic nurse and I did not consider myself a forensic nurse until I realized how I could do a better job. The difference was I did not have the legal *knowledge* at that time. Forensic nursing is having the legal and forensic science *knowledge* to give the best care I can by recognizing evidence, processing evidence, correctly charting the evidence that would be admissible in a court of law, in addition, giving the patient the best information or the best advice I can as far as what the process is going to be after she leaves the emergency room. (Q5-P07)

*Needed concepts to include.* Studies included in the Literature Review in Chapter Two reported findings that cited specific *concepts to include* in forensic nursing educational courses. Some of their recommended *concepts to include* are as follows:

In the United Kingdom, Kitchener and Rogers' (1992) study found a need for skills in the areas of counseling; behavioural and cognitive therapy, assessment of danger and risk, care of sex offenders, group or family therapy. Brooker and Whyte's (2000) study showed a need for: [inter](#)-professional training at the clinical interface, and client-centered, problem-based learning exercises that allow for reflexive learning. Martin's (2001) study in Australia showed that education is required in criminology, substance use, grief issues and counseling skills.

A study in Sweden found that what was needed in forensic psychiatric nursing was specific content in 10 categories: nursing care, developing relationships, humanistic and basic human values, theoretical models and treatment techniques, psychopathology and medication, basic and further training, in-service training adapted to the ward-



specific problems, documentation and evaluation, clinical supervision, and knowledge about other caring professions (Rask & Aberg, 2002).

A forensic nursing study in the United States found that concepts to include in curriculae were: early warning signs of victimization and offending; communication between departments in hospitals and non-nursing disciplines including law enforcement, prevention, and intervention; sociocultural issues; holistic view of family violence, information on the multidisciplinary team; more issues in pediatrics; and more on criminology, information on forensic nursing roles and responsibilities in general (Crane, 2005, p. 4). Examples from the data were:

*Knowledge Needed from Experience*

- Not just clinical experience, but also experience testifying. (Q6-P20)

*Knowledge of Theories*

- Understanding theories of violence, understanding *psychological theories* of why people do what they do. Why do people stay in abusive situations and why do people cause abusive situations? We touch on that sometimes in undergrad nursing, but, we haven't done a lot with that. So I think that why forensic...the advanced practice forensic nurse is going to make a big difference. (Q5-P17)
- You know *theories of crime* that, and I had taken some criminology before I started to teach, so, understanding those historical antecedents. (Q6-P06)

*Needed Knowledge*

- Forensic nursing is *needed knowledge* for nursing practice that is essential and integral and if the concepts of forensic nursing are not provided it could be a malpractice issue. (Q1-P03)
- Without *forensic knowledge* as integral to practice this could potentially become a malpractice issue, whether care is directed at the sexual assault survivor, perpetrator or the family/significant other needs. (Q5-P03)

*Knowledge Needed-- Concepts and skills*

- All nurses need to have some *knowledge* about *forensics* in general and know a little bit more about the chain of custody and safe collection of evidence, or correct collection of evidence preserving it, but I think that the specialization of forensic nursing its own body of knowledge. (Q12-P05)
- And it just made common sense to me that everything I was learning in death investigation was applicable to clinical nursing practice, and that

every nurse, every nurse needed to know, the basic concept of cause, manner and mechanism of death. (Q13-P08)

- Forensic photography. (Q6-P11)

(See Also Taxonomy-- Concepts to Include Appendix D3)

*2002 Taxonomy: Concepts to include.* The taxonomy from this study was compared to the taxonomy *Forensic Nursing Unique Concepts* developed by Kent-Wilkinson in 2002 (Kent-Wilkinson, 2006). See APPENDIX C3, Topics 5: Forensic Unique Concepts developed by this researcher in 2002, the concepts were organized into 5 main Forensic topics and 13 Forensic Modules (See Table 5.2b, *Forensic Topics and Modules, 2002*).

Table 5.2b

*Forensic Topics and Modules, 2002 (See Appendix C3)*

<i>Topics (5)</i>	<i>Modules in each Topic (13)</i>
<ul style="list-style-type: none"> <li>• Forensic Nursing</li> <li>• Forensic Medicine</li> <li>• Clinical Forensic</li> <li>• Forensic Psychiatry</li> <li>• Prison Health</li> </ul>	<ul style="list-style-type: none"> <li>• Forensic History</li> <li>• Forensic Laws/Legal/Policies</li> <li>• Forensic Theories</li> <li>• Forensic Specialties &amp; Roles</li> <li>• Forensic Systems &amp; Services</li> <li>• Forensic Practice</li> <li>• Forensic Assessment</li> <li>• Forensic Populations</li> <li>• Forensic Concepts</li> <li>• Forensic Issues</li> <li>• Forensic Education</li> <li>• Forensic Research</li> <li>• Forensic Careers</li> </ul>

The 2002 taxonomy was developed from my experience of writing several forensic nursing courses. In comparing the two taxonomies, the concepts found in this study that I did not include in the content in my 2002 taxonomy (Kent-Wilkinson, 2006) were:

- Accidents
- Boundary violations
- Intersectoral collaboration
- Toluidine Blue

The concepts included in 2002 taxonomy (Kent-Wilkinson, 2006) that did not appear in this research study were:

- Issues of Treatment and Warehousing, Restraint and Seclusion
- Fitness to Stand Trial
- Not Criminally Responsible (NCR)
- Not Criminally Responsible due to a Mental Disorder (NCRMD)
- Homicide/Spousal Homicide/ Filicide

#### *Constructed Connotations of Knowledge Needed & Concepts to Include Theme*

One result of this study was a *taxonomy of 111 concepts of forensic nursing* (See Appendix D3. Concepts to Include). This taxonomy could be used by future educators as a check of which *concepts* are common to include in the curriculum. However, this taxonomy did not provide the importance or weight of each one, or the order of where they should be presented in any course. The weight of *concepts* could be examined in a future study. From a constructivism perspective, the following data extract was relevant to this study.

#### *Statement of Concepts to Include (Constructed)*

- ❖ Forensic nursing incorporates not only *concepts* from the forensic sciences but the forensic behavioral sciences. Forensic nursing looks at not only the physiological effects of trauma on victims, but also the psychological

consequences; perpetrator behavior, assessment and intervention, and care of the deceased from unnatural causes and the impact on the family.

*Knowledge Needed--Laws & Acts (Constructed)*

- ❖ Forensic nurses (as all nurses) *need to know* the laws and acts that apply to their practice. For example, in Canada, The Charter of Rights and Freedoms, Bill C-31 on mental Disorder, the Mental Health Act, the Public Hospital Act and the Child Services Act, etc

*Needed Experience (Constructed)*

- ❖ Not just clinical experience, but also experience testifying.

*Knowledge of Theories (Constructed)*

- ❖ Forensic nurses need to be taught the theories of violence and crime to understand the psychological theories of why people do what they do? Why do people stay in abusive situations and why do people cause abusive situations?

*Needed Knowledge (Constructed)*

- ❖ Forensic nursing is *needed knowledge* for nursing practice that is essential and integral and if the concepts of forensic nursing are not provided it could be a malpractice issue. Without forensic knowledge this could potentially become a malpractice issue, whether care is directed at the sexual assault survivor, perpetrator or the family/significant other needs.
- ❖ All nurses *need* to have some *knowledge* about the forensic sciences in general and know a little bit more about the chain of custody and safe collection and preservation of evidence; how to write to be able to generate reports that follow coherent guidelines; every nurse needs to know, the basic concept of cause, manner and mechanism of death.

*Theme 5.3. Differential Knowledge of Forensic Nursing*

*Differential knowledge* referred to the degree of difference in knowledge and *knowledge differentiation* is that separation of knowledge isolated to show the differences between knowledge. How forensic nursing was different from nursing in general, and how it is different from other forensic disciplines became an important finding of the study. It also contributed more clarification for the definition of forensic nursing by adding further explanations in addition to the definition of what forensic nursing is, by clarifying what it is not, and how it is the same or different from nursing in general and

other forensic disciplines provided a greater understanding (See Table 5.3. Differential Knowledge of Forensic Nursing Theme).

*Literature Comparisons Differential Knowledge of Forensic Nursing Theme*

The literature revealed that forensic nurses in some subspecialties have attempted to sort out what is unique about their subspecialties of forensic nursing. A study by Robinson and Kettles (1998) looked at what was similar and different about the role of forensic nurses compared to general psychiatric/mental health nurses, and also examined what was similar and different about the role of the forensic nurse compared to the multidisciplinary team. Robinson and Kettles conducted a qualitative study “aimed to ask a sample of 72 staff in 10 forensic units (from Scotland and England) eight questions relating to the role and training of forensic nurses” (p. 214).

Table 5.3a.

*Theme: Differential Knowledge of Forensic Nursing from Nursing*

*More likely - Differences*

- 
- more likely to care for offenders and victims on a continual basis. (Q5P05)
  - more likely that the case & documentation will end up in court. (Q5-P20)
  - more likely to rely on the knowledge from law and forensic science. (Q4-P07)
  - more likely to interface with the justice system. (Q1-P16)
  - prepared differently. (Q5-P17)
  - practice with a different group. (Q5-P17)
  - different focus of the interview. (Q5-P20)
  - different focus of the patient. (Q5-P20)
  - different focus on body as a crime scene. (Q5-P10)
  - different assessments: risk, criminal responsibility, physical assessments and exams. (Q5-P01)
  - different care environments, systems and services to different or special populations. (Q5-P10)
  - different management of medication administration for offenders. (Q2-P10)
-

Table 5.3b cont.

*Theme: Differential Knowledge of Forensic Nursing from Forensic Disciplines*

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*More Likely - Differences*

---

- nursing's holistic approach. (Q1-P19)
  - nursing's more objective approach. (Q3-P15)
  - care of victims and perpetrators
  - philosophy of care or paradigm of care. (Q5-P11)
  - dual role of health and healing. (Q5-P20)
  - dual role of coordinator of team and of patient care
  - knowledge of systems. (Q5-P01)
  - medication management & administration. (Q5-P01)
  - social sense of continuity of care. (Q5-P11)
  - need to ensure or be responsible for maintenance of therapeutic contact
  - cross-over responsibility role for victim and their extended human contacts. (Q5-P11)
  - focus on injury and role of violence. (Q5-P17)
  - assessments (physiological domain) done by nurse (in place of the physician). (Q5-P01)
  - More likely to work in the clinical area. (Q1-P11)
- 

*Differences between forensic nursing and mental health nursing.* Results of Robinson and Kettles (1998) study indicated there was such a person as a forensic nurse and that there were subtle differences from the general psychiatric role. The differences of forensic psychiatric nursing from mental health or psychiatric nursing were the care of patients in a locked environment, juggling the roles of therapist and gatekeeper, and the balance of care and custody.

Other distinctions between general mental health nursing and forensic nursing were the depth, quality, complexity, and intensity of the therapeutic relationship over time and the level of security and control. Offending behaviours were often violent behavioural characteristics that demanded advance professional competence. Dilemmas were the balance of the need for security against therapy whilst moving patients toward rehabilitation and life in the community (Robinson & Kettles, 1998).

Examples of data extracts of the knowledge of forensic nursing *different from nursing in general* were:

*Care of Victims and/or offenders on a Continual Basis*

- Forensic nurses are different because we are taking care of individuals that are victims of either violent acts or traumatic occurrences all the time, whereas nurses in the general population may take care of those same types of victims but not on a continuous basis. (Q5-P05)

*More Likely/High Likelihood / Possibly/ More Prominently*

- Forensic nursing is where nurses work with patients, who have a high likelihood of interfacing with one of the justice systems, whether that be a civil justice system or a criminal justice system. (Q1-P16)
- Forensic nursing interfaces with the law, a big component (focus) is the documentation and collecting of evidence. The technical aspects of...preserving the chain of custody are things are not necessarily in the other nursing courses. Which is the law...is much, prominently there on the spot, they, they need to know quickly a knowledge of the law. (Q5-P05)
- Forensic nursing is more likely to rely on knowledge from the discipline of law, and forensic science. (Q4-P07)
- In any nursing practice is always a possibility that this will end up in court, but this is likely something that will end up in court, and so while we always need to keep that in mind, I think with our forensic nursing practice that has to be in the forefront. (Q5-P2)

*Different Focus from Nursing in General*

- Forensic nursing's understanding of the law is not typically included in nursing in general. (Q5-P12)
- Awareness that our interactions with these client populations, possibly has a legal implication. (Q1-P12)
- Nurses, at least in this country are rather limited in their knowledge of the law and what goes on in a court room after the patient leaves there. (Q8-P07)
- Forensic nursing is unique in that we practice with a different group of collaborators in relationship to the patient. (Q5-P17)
- Forensic nurses are prepared in a different way. We have scientific knowledge, legal knowledge, nursing knowledge. (Q5-P17)
- Core concepts that are different from nursing in general are: I do believe it's looking at the patient in a different way so that its understanding that that patient who comes in may be a victim of violence, or the person who comes in who is a perpetrator of violence. (Q5-P17)
- I think it's clearly the focus on the interview, focus is somewhat different, in that we're looking at what another person did to them. So that

interview documentation I think is has to be more objective and then of course, chain of custody. I think that, chain of custody is huge, and that's something that doesn't, isn't normally in our nursing practice. In fact it isn't at all. (Q5-P20)

- How we manage the administration of medication differently. Some of the common health care concerns of incarcerated populations that may differ from general populations, and the why. (Q2-P10)
- Some of these assessments the nurses might do particularly in the physiological domain that are unique to nurses. (Q5-P01)
- What makes forensic applications different, whether its in a community, or in a correctional setting or in an emergency room, or whatever is that whole focus on everything I'm doing is not only meeting the needs of this immediate client, but also have direct implications for possibly prosecution or the safety of the community, or the environment. (Q5-P10)

*Differences between forensic nursing and other disciplines.* Some of the differences from other forensic disciplines were: provision of care to this complex and challenging group of patients, 24 hours a day and 365 days a year; observation of patients 24/7 in interactions; holistic view of patients; coordinator of patient care, ability to manage the environment; endure the intensity of the ward which other disciplines do not; responsible for the safety of everyone on the ward, whereas other professionals were only responsible for their own safety and working to a professional code of conduct (Robinson & Kettles, 1998).

Examples of data extracts from this study of forensic nursing knowledge *different from other forensic disciplines* were:

*Nursing*

- Nursing is health focused and comprehensive, unlike medicine which is disease focus. (Q1-P19)
- Nursing has always been the best provider, from a forensic point of view to the patient who has to intersect with the legal system. (Q1-P19)

*More Objective*

- I see nurses as being the most objective of all those people on the team (Q3-P15)



### *Holistic*

- Holistic health care within a forensic context. (Q5-P02)
- With the holism, it makes the objective answer clearer. (Q3-P15)
- Forensic nursing is different from other forensic disciplines because of nursing's holistic approach to problems, knowledge of systems, and perhaps our philosophy of care comes in there as well. (Q5-P01)

### *Different Unique tasks*

- Some of the unique tasks of nursing are different from other disciplines for example, medication administration and supervision and evaluation of the impact of medication, some of these assessments the nurses might do particularly in the physiological domain that are unique to nurses. (Q5-P01)

### *Health and Healing--Caring Paradigm*

- So what I think is unique knowledge of forensic nursing is that higher level evidence for how do we promote health and healing, through a caring paradigm. (Q5-P10)
- Forensic nurses have a cross-over between responsibility for the living victim and their extended, human contacts. (Q5-P11)

### *Social Sense for Continuity of Care*

- Where most of the time in the rest of forensic science you really don't have that, you're operating on a victim, or a suspect, or a known offender, and you don't tend to have a social sense of continuity, having any sort of a need, or a responsibility for ensuring some sort of a therapeutic contact is maintained with the person. (Q5-P11)

*Differences - -nursing is a clinical practice discipline.* Those who specified nursing as a professional discipline emphasized that nursing has a “social mandate to develop, disseminate and use knowledge. In contrast academic disciplines such as physics, physiology, sociology, psychology and philosophy are mandated only to develop and disseminate knowledge (Fawcett, as cited in Barrett, 2002, p. 55).

Nursing is a practice discipline, therefore, knowledge development is key at the clinical practice interface. Brooker and Whyte (2000) in a report aimed at multidisciplinary team-working in secure psychiatric settings argued that interprofessional training should take place at the clinical interface. They also added that

it should focus on client-centered, problem-based learning exercises that allow for reflexive learning. Examples from the data extracts were:

*Clinical Setting More Likely*

- Cause we've got a combination of, the science part and the humanity part. I think most of the other forensic science operate in a pretty laboratory like environment for the most part and are fairly well confined most of the time, whereas forensic nurses are in the clinical setting. (Q5-P11)
- And I think that the clinical setting, and, the health care aspects, like infection control, and dealing with infectious organisms, and dealing with, reporting things for insurance companies, and I'm trying to think primarily third party payer type issues. You just don't face that in other forensic disciplines. Well I think that's somewhat unique. (Q5-P11)

*Constructivism Connotations Differential Knowledge of Forensic Nursing Theme*

In nursing, *care* or the *caring paradigm* most often means the 24 hour care of the patient, the continuous care across the lifespan, and most often the coordinator of care. The ability and desire to provide this continuous care is one reason why nurses were able to expand their role. As an example, the sexual assault exam is either performed by the physician or by the nurse. In many areas now, this role is only filled by the sexual assault nurse, because physicians either could not, or did not want to be available 24 hrs a day to meet this need and/or they did not want to take the time to go to court.

The SANE role is an example where nurses expanded their role, so that in many areas of Canada and the United States the forensic nurse as the sexual assault examiner fulfills this role, and the physician is no longer part of the team. This example provided evidence for the importance of the *continuous care* role of nursing where *care* means 24/7/365 *care* that extended to the family, and to the community. This example also provides evidence that nursing is a practice discipline, meaning practice in the clinical setting, which is not always the case with other forensic disciplines, as many work in

laboratory settings only.

*Forensic Nursing Different from Nursing in General (Constructed)*

*More Likely Differences*

- ❖ Forensic nurses are more likely to be caring for patients who are victims or offenders on a continual basis, therefore their practice has a high likelihood of interfacing with one of the justice systems. Forensic nurses are more likely to rely on the knowledge from law & forensic science, and it is more likely that the case and their documentation will end up in court.
- ❖ Forensic nurses practice with a different group of collaborators in relationship to the patient.
- ❖ Forensic nurses are prepared in a different way with forensic scientific knowledge, legal knowledge, and nursing knowledge.
- ❖ Forensic nurses look at each patient in a different way understanding that that patients may be a victim of violence, or the person may be a perpetrator of violence.
- ❖ The focus of the interview is somewhat different, in that forensic nurses are looking at what they did to another person, or another person did to them, so documentation has to be more objective, and chain of custody needs to be preserved which is a concept not normally taught in general nursing.
- ❖ Forensic nurses may manage the administration of medication differently for some of the common health care concerns of incarcerated populations which may differ from general populations.
- ❖ Some of the assessments are different that the forensic nurses might do particularly in the physiological domain, example sexual assault examinations.
- ❖ Forensic applications are different, whether its in a community, or in a correctional setting or in an emergency room, in that whole focus on everything is not only meeting the needs of this immediate client, but also have direct implications for possibly prosecution or the safety of the community, or the environment.

*Forensic Nursing Different from Other Forensic Disciplines (Constructed)*

*More Likely Differences*

- ❖ Different from other forensic disciplines that also lay claim to a caring paradigm, forensic nursing's caring paradigm is more likely to include not only therapeutic aspects of caring but also a holistic and objective approach, and a social sense of responsibility for the continuous 24/7/365 care, where contact is maintained with the client, with extension of that role to the family and community.
- ❖ Different from other forensic disciplines, forensic nursing is more likely to be knowledge applied at the clinical/legal interface as not all disciplines have a clinical component.

- ❖ Forensic nursing, different from other forensic disciplines are more likely to provide care and services to both victims and offenders, living and deceased.

#### *Theme 5.4. Dual Knowledge*

Specialty areas of practice may bring with them *dual knowledge*, dual roles, and dual paradigms. This study addressed the *dual knowledge*, roles, and paradigms of the forensic nursing specialty and how these roles often conflict (See Table 5.4. Dual Knowledge Theme).

Table 5.4

*Theme: Dual Knowledge*

<i>Dual Role</i>	<i>Dual Paradigms</i>
<ul style="list-style-type: none"> <li>• Care and Custody. (Q8)[P01]</li> <li>• Care and Collection of Evidence. (Q2-P05)</li> <li>• Care and Chain of Custody. (Q12-P05)</li> <li>• Care and Court Testimony. (Q5-P20) (Q5-P8)</li> <li>• Care and Community Protection. (Q5-P10)</li> <li>• Care and Collaborator/Coordinator.</li> <li>• Care and Crisis Intervention. (Q11-P12)</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate and Scientist</li> <li>• Art and Science</li> <li>• Humanistic and Objective</li> <li>• Conflicting ideologies</li> <li>• Dichotomy of roles</li> <li>• Paradoxical role</li> <li>• Care of Victims &amp; Offenders</li> </ul>

#### *Literature Comparison to Dual Roles Dual Paradigm Theme*

Although there is much in the literature about the dual roles of *custody and caring* within forensic psychiatric/ correctional nurses, there is also evidence in the literature about forensic nurse examiners who care for victims experiencing dual roles of *care and collection of evidence* and *care and court room testimony*

*Care and custody.* The forensic psychiatric mental health literature has many studies that address the dual roles of *caring and custody* and how these roles often

conflict. Although mental health nurses have delivered care within correctional institutions throughout the developed world for much of this century, their practice has been subject to conflicting ideologies: “health care provision and its science of health care versus criminal justice with its sociological based disciplines of penology and correction” (Doyle, 1999, p. 33).

“The central theme in defence of specialist practice is usually founded in the dichotomy of ‘therapy versus custody’” (Burnard, 1992; Burrow 1991a, 1991b; Mercer, et al., 2001, p. 109). The discourse on forensic nursing produced a form of knowledge in which patients needed care as well as to be in custody (Sekula et al., 2001). In forensic psychiatric/correctional nursing, *care and custody* has taken center stage. Here the humanistic values of the mental health system constantly clash with the security goals of the criminal justice system. “In our own practice we sometimes find it difficult to project a caring humanistic approach when security, a specialized component of the correctional institution has to be constantly kept in mind” (Kent-Wilkinson, 1993, p. 26). An example in the data of this study of *dual role of caring and custody* is:

- Most satisfying in teaching forensic nursing is facilitating students in their struggles to come to terms with their *dual roles*, and the ‘ah hah’ that occurs when they recognize how easy it might be to abandon their nursing roles, and be co-opted by the custodial system. (Q8-P01)

*Dual role of caregivers and evidence collectors.* A population based study by Du Mont & Parnis (2003) in Toronto found that many SANEs reported experiencing dilemmas with respect to their dual roles as *caregivers and evidence collectors*. Examples from the data are:

- All nurses need to have some knowledge about *forensics* in general and know a little bit more about the *chain of custody and safe collection of evidence*, or correct *collection of evidence* preserving it. (Q12-P05)
- Not just *clinical experience*, but also *experience testifying*. (Q6-P20)
- Today nurses are uniquely qualified to *testify in court* about the consequences of violence because so many physical and mental illnesses and injuries from criminal acts require first the *care* of nurses. Previously, this was not considered to be in the purview of nursing. (Q5-P08)
- The whole focus on everything I'm doing is not only meeting the needs of this immediate client, but also have direct implications for possibly prosecution or the *safety of the community, or the environment*. (Q5-P10)
- Forensic nursing incorporates intrinsic values of *caring and health promotion and advocacy* embedded in nursing. (Q1-P10)
- *Assessment of the role of violence* in the hospital admission is something forensic nurses do-- now becoming and mandated as standard practice for health care professionals that they must *assess for history of violence and cause of violence* if due to violence. (Q5-P17)
- Forensic nursing has not only *forensic skills*, but also the *crisis intervention*, being able to inform people of their choices and providing the appropriate health care have all proven to be beneficial. (Q11-P12)

*Unique knowledge of nursing and unique knowledge of forensic nursing.* A body of knowledge that does not include caring and human health experience is not nursing knowledge (Newman, et al., 1991, p. 3). Within secure psychiatric settings, forensic nurses must provide care for and maintain custody of forensic patients, a paradoxical role that makes this type of nursing unique (Gudgeon, 2004). Mason and Carton (2002) noted that there was one point of uniqueness, although difficult to define, is highlighted in the literature as the contrasting aims of caring and custody. An example from the data was:

#### *Dual Roles*

- Facilitating students in their struggles to come to terms with their *dual roles*. (Q8-P01)

*Nursing as an art and science.* Professional nursing is a science and an art. The science of nursing requires that nurses study, explore, and research nursing and related

knowledge areas. From these areas nurses develop and test nursing theories for the improvement of nursing practice and health care. The art of nursing requires that nurses use knowledge gained from the humanities, arts, and sciences as the foundation for acceptance and appreciation of clients' values. Nursing care requires sensitivity as well as critical, logical, and analytical thinking to effect changes in clients and the health care system (SRNA, 2007). Nursing embraced the definition that nursing is the art and science of caring (Leininger, 1984). Seen as an art, nursing encompasses intuitive, expressive, subjective, creative, humanistic and holistic dimensions that find expressions through our therapeutic use of self. "Meanwhile, the science of nursing is that body of knowledge unique to nursing" (Kent-Wilkinson, 1993, p. 25). Examples of data extracts were:

- Forensic nursing is a combination of, the *science part and the humanity part*. (Q5-P11)
- To provide students with a repertoire of skills in *both domains*. (Q3-P06)
- Balancing out to make sure we want to provide a high level quality forensic nursing service and at the same time, so it goes back and forth between talking to the client, supporting the family, you can get lost in all the technology. (Q11-P12)

The participants in this study expressed conflicting ideologies as to which was more important, the science or the art. Examples from the data were:

*Science more Important*

- The current construct was we're looking at forensic nursing as a nursing science not as a social service. Because when you go into a court room, you have to appear as a scientist not as a victim advocate. And that is very hard for nurses to get through there heads because it just kind of changes their thinking. (Q8-P11)
- We needed to let people know that even though there are components of, human elements in that the real core, if we're going to be serious forensic nurses, has got to be the science of forensic nursing which has got to be

objective, and the passion has got to be about the science, not the person. (Q8-P11)

- Nurses generally get too involved with the, the person, rather than think about it objectively as to what is the truth. (Q8-P11)

#### *Person (Humanistic) Role More Important*

- I think to get exceptional high quality nursing care where the nurses have the knowledge and skill around the forensic piece. The forensic piece is important, but I think that at the end of the line the client's going to remember that interaction with the nurse, versus the fact of some forensic tool that was used. (Q3-P12)
- The nursing side is more important. Certainly I think what a victim benefits from the nursing side versus the forensics, in the long run. (Q2-P12)
- Not victim or offender but the person. (Q3-P15)

#### *Conflicting Roles*

- The police would say the students "So why don't you just be the nurse, and I let me be the cop" Why are you trying to be the cop? So we had a bit of resistance initially, not now. (Q9-P03)
- Nursing focus is primary one (in forensic nursing).(Q3-P20)
- Focus area of nursing is forensic. (Q3-P16)

#### *Victim and Offenders*

- And so to say one more important than the other, would be I think really difficult for me to say if we can identify the offenders, if we can provide preventative intervention in any of the other areas of forensic nursing. (Q2-P08)
- There is no way really to separate victims or offenders because often, we are taking care of offenders and don't even realize it, and yet the processes of the forensic nursing aspect, in terms of investigations and evidentiary management and documentation are essentially the same. (Q2-P11)

#### *Constructed Connotation to Dual Roles Dual Paradigm Theme*

From a constructivism approach, significant to this study was that the dual roles of forensic nursing come from the art and the science constructions of nursing. Although a few compelling arguments were made throughout the data set for one over the other, overall the consensus was that both the art and the science dimensions are needed in



forensic nursing. From a constructivism perspective, both the art and the science of forensic nursing are important and neither one more so than the other. *Both/and* are important rather than *either/or*. Examples from the data were:

- ❖ Forensic nursing is a combination of both nursing science and nursing art.

If the knowledge that is different between forensic nursing and nursing is the *forensic* knowledge, and the knowledge that is different between forensic nursing and other forensic disciplines is the *nursing* knowledge, it was deduced that the *dual roles* or *dual knowledge* may be what is *unique knowledge* of forensic nursing. In the data analysis of this study it became clear that the *unique knowledge* of forensic nursing was the dual roles of *caring* and whatever concept was unique to each subspecialty: such as custody, collection of evidence, court testimony, crisis intervention, or chain of custody.

Constructed dual roles are:

- ❖ Forensic nursing is a specialty of nursing where the core (unique) components are the dual roles of care and concepts specific to each subspecialty, for example:
  - ❖ Care and Custody
  - ❖ Care and Collection of Evidence
  - ❖ Care and Chain of Custody
  - ❖ Care and Court Testimony
  - ❖ Care and Crisis Intervention
  - ❖ Care and Coordinator/Collaborator of Care
  - ❖ Care of Client and Community Safety

#### *Theme 5.5. Knowledge Defined/Definition (Constructed)*

In the first part of the main research question for this study, I asked what the knowledge of forensic nursing was. In determining a *definition* of forensic nursing it was determined that the constituent components of the *definition* would not only be found in

the data extracts included in the categories determined for Question 1, “What is Forensic Nursing?”, but also in the data extracts of how forensic nursing was described throughout the remaining questions and within the main themes of the study (See Table 5.5. Forensic Nursing Definition). Definitions of forensic nursing found in the literature were also cited for comparison. Finally, a result or finding of this study was a *Definition of Forensic Nursing* theme constructed.

Table 5.5.

*Theme: (Forensic Nursing) Knowledge Defined (Constructed Definition)*

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*Definition Constructed from the Significant Themes/Typologies of the Study*

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- Care
- Conceptualization of Forensic Nursing
- Philosophical base
- Recognized Specialty of Nursing
- Nursing Specialty with a Forensic Focus
- Forensic Population Served
- Law/Legal Interface/Relationship
- Knowledge Needed (knowledge from other forensic disciplines)
- Unique Knowledge (unique aspects)
- Differential Knowledge
- Roles (Expanded Role)
- Dual Roles
- History (why and how evolved)
- Constructivism (Dual Roles, Combo, Both/And)

*Literature Comparisons of Definitions of Forensic Nursing*

*Definitions of Forensic Nursing*

- IAFN’s original definition of Forensic Nursing
- IAFN’s recent definition of Forensic Nursing
- Other Definitions of Forensic Nursing

*Constructivist Connotations of Definitions of Forensic Nursing*

- Result--A Constructed Definition
-

### *Literature Comparisons of the Definition of Forensic Nursing*

I chose examples of past and current definitions of forensic nursing from the literature that had been written and developed by individuals or groups and adopted by professional associations. This creation of a definition of forensic nursing may be the first time a definition was constructed using research methodology.

- There was a period of time where we were *defining* ourselves and you can't teach something when you're not doing it yourself. First there was working toward who we are and what we do and getting comfortable with that first. (Q12-P15)
- It only been recently that organizations like IAFN *defined* forensic nursing and up to that point, everybody was defining it for themselves. (Q9-P11)

*2006 IAFN definition.* An updated definition by Lynch, in 2006 was adopted by IAFN Board, "Forensic nursing is defined as the global practice of nursing when health care and legal systems intersect (IAFN, 2006b).

*2006 IAFN subspecialties and service definition.* Forensic nursing provides direct services to individual clients, consultation services to nursing, medical and law related agencies, and expert court testimony in areas dealing with trauma and/or questioned death investigative processes, adequacy of services delivery, and specialized diagnoses of specific conditions as related to nursing. Forensic nurses also work with families, or significant others, and the community (IAFN, 2006a).

*1993 IAFN/1991 Lynch definition.* The following definition by Lynch in 1991 was adopted and adapted by the IAFN Board: "Forensic nursing is the application of the forensic aspects of health care combined with the biopsychosocial education of the registered nurse in the scientific investigation and treatment of trauma, and or death of

victims and perpetrators of violence, criminal activity, and traumatic accidents within the clinical or community institution” (IAFN, 1993a).

*1990 Lynch definition.* Forensic nursing is “the application of the forensic aspects of health care combined with the bio-psychosocial and spiritual education of the registered nurse in the scientific investigation and treatment of trauma, and or death or related medicolegal issues" (Lynch, 1990, p. 49).

#### *Constructed Definition of Forensic Nursing*

##### *Definition Constructed - (Constructed assumption statements from the data)*

- ❖ Forensic nursing is a specialty of nursing.
- ❖ Forensic nursing is not a nursing specialty in forensics.
- ❖ Forensic nursing is nursing practice that in some way pertains to or interfaces with the law.
- ❖ Forensic nursing is an emerging, evolving specialty.
- ❖ Forensic nursing is nursing’s response to violence.
- ❖ Forensic nursing is needed knowledge
- ❖ Forensic nursing is nursing practice at the clinical legal interface
- ❖ Forensic nursing is a focus area of nursing practice where a dual role with care is the core component.

##### *Knowledge Definition (Constructed)*

- ❖ Forensic nursing is a recognized specialty of nursing where care for the client is focused at the clinical legal interface.
- ❖ Forensic nursing occupies a global position of care in the human health experience of violence in society.
- ❖ Forensic nursing is a focus or specialty area of nursing that provides care/services for unique populations of people (victims, perpetrators/ deceased and families) who have health care problems where there are legal implications for the prevention and protection of the community and society.
- ❖ Forensic nursing is the applied knowledge combining the art and science of nursing with forensic science, forensic medicine, forensic psychiatry, criminology, victimology and law, for the care of populations who may be victims, offenders or the deceased.
- ❖ Forensic nursing incorporates concepts from both the forensic sciences and the forensic behavioral sciences.

*Different from Nursing in General (More Likely Differences)*

- ❖ Forensic nurses are more likely to be caring for patients who are victims or offenders on a continual basis, therefore their practice has a high likelihood of interfacing with one of the justice systems. Forensic nurses are more likely to rely on the knowledge from law & forensic science, and it is more likely that the case and their documentation will end up in court.
- ❖ Forensic nursing practice with a different group of collaborators in relationship to the patient.
- ❖ Forensic nurses are prepared in a different way with forensic scientific knowledge, legal knowledge, nursing knowledge, and many others and know how to work with others collaboratively.
- ❖ Forensic nurses look at the patient in a different way understanding that that patients may be a victim of violence, or the person may be a perpetrator of violence.
- ❖ The focus on the interview is somewhat different, in that forensic nurses are looking at what another person did to them, so documentation has to be more objective, and chain of custody needs to be preserved which is a concept not normally taught in general nursing.
- ❖ Forensic nurses may manage the administration of medication differently for some of the common health care concerns of incarcerated populations which may differ from general populations.
- ❖ Forensic applications are different, whether its in a community, or in a correctional setting or in an emergency room, in that whole focus on everything is not only meeting the needs of this immediate client, but also have direct implications for possibly prosecution or the safety of the community, or the environment.

*Different from Other Forensic Disciplines (More likely Differences)*

- ❖ Different from other forensic disciplines forensic nursing is more likely to be knowledge applied at the clinical/legal interface, where care and services are provided to both victims and offenders, living and deceased.
- ❖ Different from other forensic disciplines that also lay claim to a caring paradigm, forensic nursing's caring paradigm is more likely to include not only therapeutic aspects of caring, but also a holistic and objective approach with a social sense of responsibility for the continuous 24/7/365 care, where contact is maintained with the client with extension of that role to the family and community.

*Dual Knowledge (Constructed)*

- ❖ Forensic nursing is the applied knowledge combining the art and science of nursing with forensic science, forensic medicine, forensic psychiatry, criminology, victimology and law, for the care of populations who may be victims, offenders, living or the deceased.

*Dual Roles (Constructed)*

- ❖ Forensic nursing is a specialty of nursing where the core (unique) components are the dual roles of care and concepts specific to each subspecialty, for example, care and custody; care and collection of evidence; care and court testimony; care and chain of custody, etc.
- ❖ *Forensic Nursing Process (Constructed)*  
The principles of forensic nursing are an integral part of the nursing process. Forensic nursing is a combination of not only the nursing process, but also includes elements of the scientific process, the legal process, and even the political process.

*Forensic Nursing History (Constructed)*

- ❖ Forensic nursing evolved from the need to increase the care to victims and perpetrators, both from societal need and from our own need to improve the services.

*Forensic Theory (Constructed)*

- ❖ Forensic nursing blends the components of nursing's caring paradigm and a multidisciplinary practice model within a public health framework, under an overarching theory of social justice. Forensic nursing is a combination the nursing process with elements of the scientific process, the legal process, and a public health approach. Forensic nursing encompasses the nursing paradigm with its own unique definitions of person, health, environment and nursing

Theme 5.60: Knowledge or Educational Development--Factors Influencing

The theme of *factors influencing* educational development was a summary of the key findings of the qualitative questions 8-13. The responses to these six questions answered the second part of the main research question of this study. The *factors influencing* theme was divided into the following three sub-themes:

*5.6a. Positive and Negative Factors Influencing*

*5.6b. Historical Factors Influencing*

*5.6c. Significant Persons as Factors Influencing*

*Theme 5.6a. Positive and Negative Factors Influencing*

Both *positive and negative* influences have had an impact on the factors influencing forensic nursing educational development. From a constructivism approach

*influencing factors* is represented from Dewey's (1938) original interpretation of constructivism *it depends* as well as *both/and* and *not/only/but also* (See Table 5.6a. Positive and Negative Factors Influencing theme).

Table 5.6a.

*Theme: Positive and Negative Factors Influencing*

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*Sub Themes*

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- Satisfying Most/Least Satisfying
  - Organizational Foster/Hindered
  - Educational Institutional Support/Non supportive
  - Social (Positive/Negative Influences)
  - Media (Positive/Negative Influences)
  - Technology (Positive/Negative Influences)
  - Economic (Positive/Negative Influences)
  - Political (Positive/Negative Influences)
  - Sustaining factors (Positive/Negative Influences)
  - Partnerships/Affiliations (Positive/Negative)
- 

*Literature Comparisons to Positive/Negative Factors Influencing Theme*

The literature provided the following references for a *positive and negative* theme. The social, media, technology, and economic factors were shown in the literature to have influenced the forensic area.

*Positive/negative category/theme.* Positive and negative as a research category, was used in prior forensic nursing research. In the United Kingdom, Mason (2002) conducted a literature review and thematic analysis of role tensions of forensic psychiatric nursing. He identified a series of major issues, which were broadly categorized as negative and positive views, security vs. therapy, management of violence,

therapeutic efficacy, training, and cultural formation (Mason, 2002). Later studies by Mason, Lovell, & Coyle (2008) on the investigation into the skills and competencies of forensic psychiatric nurses also showed positive and negative views as some of the main themes to emerge. A dichotomy of roles, populations, paradigms and themes appear to be common in the forensic area.

*Bandwagon effect.* The downside of courses being popular was the bandwagon effect. This bandwagon effect was found in the literature. "There's more interest in forensics because of the increased media exposure on shows like CSI and Law and Order" (Naiman, 2006). Examples from the data were:

- I do have a fear however, that some universities may be starting forensic programs because they're a popular topic. Yet I'm unclear whether the faculty that are being chosen to teach it truly know what they're teaching. (Q10-P16)

*Social acceptance/image of nursing- - positive (present)/ negative (past).* Gallop polls from both the United and Canada ranked nursing as the most trusted profession, whereas medical doctors were ranked seventh and fifth (Gallup Poll, 2004; IPSOS News Centre, 2007; Nurses remain the most-trusted professionals, 2003). These public polls increased the awareness and positive identity of nursing. Although nurses have always been in a position to add value to the identification, treatment, and referral process of victims and offenders of violence, is only now being recognized. Examples from the data were:

- Macleans did a survey across Canada that I just recently pulled...it was that nurses are the second or third most trusted...far above police officers, doctors, lawyers, you name it? And I think firefighters were the number one. (Q11-P09)



- I think society's acceptance of the nurse...And particularly that it's the most trusted profession in the U.S., from a survey in the US. (Q11-P19)

*Social movements.* Social movements and public policies have positively and negatively influenced the development of forensic nursing, and the delivery of forensic nursing education. Radical changes have occurred in education and technology, at a time that has also come for a global interest in the forensic sciences (Kent-Wilkinson, 2006).

Examples from the data were:

- A lot of opportunities in forensic nursing emerged because people saw this sexy, different, possibly more powerful, more aligned with medicine, more prestigious opportunities in which to apply their nursing skills. (Q2-P10)

*Media influences.* The recent trend and interest in the forensic subject matter in the media, due to the increased attention to violence in our society and media exposure of high profile cases, has benefited the forensic behavioural sciences (Kent-Wilkinson, 2006). Examples from the data of positive and negative influences of the media were:

- Certainly television programs like CSI have influenced it. Forensic science has been brought into the home of almost every American, as well as internationally has highlighted it in a very positive sense [in society]. (Q11-P08)
- With media and technology, a wider population has become aware of the forensic world. (Q11-P03)
- Then socially, news media articles, recognition by the media, forensic nurse examiners have all brought a positive perspective to nurses who provide care for victims of domestic violence, and child abuse, sexual assault, where previously that type of support wasn't there. Where historically as you and I both have remarked in the past, [forensic nursing] had a very negative concept [in society]. (Q11-P08)
- They don't really say what the discipline background of some of these people that work on CSI, but you know they're not nurses. So the media has not promoted it well. (Q11-P05)

*Online education technology.* A challenge in educational technology is the dissemination of forensic body of knowledge internationally. The value of accessing and utilizing forensic experts and resources internationally on the Web is just beginning to be realized, with a greater number of international links promised (Kent-Wilkinson et al., 2000). In the past, distance education was considered a prepackaged text or audiovisual course, with little or no provision for interaction between the student and the instructor. Today, the evolving interactive communication technology allows learning experiences to occur at any time between instructor and student, student and student, and student and expert (Kent-Wilkinson et al., 2000). Examples from the data of the positive and negative impact of online forensic nursing educational development were:

- The acceptance for distance education through computer applications, I think is getting to be just expected and, which gives us greater access to focus its really needed. (Q11-P06)
- It's been a *plus and a negative*, because some students. Some learners just really struggle with the distance, the web-based courses. And they need you right there holding their hands. There's a whole group of learners out there, maybe 30 and older, who can work a computer, they are Generation X. But we the baby boomers really grew up with, that education is really the teacher's responsibility it's your responsibility to come, give me everything I need, while distance education really requires the learner to take much more responsibility, spoon feed. (Q11- P06)
- So I think it'll be. I think it will really be a boon for the people that are coming forth now, but also it's still is a challenge for a lot of old learners. (Q11-P10)

*Economic factors influencing.* Sexual assault examination training has been found to save the government in prosecution costs. Massachusetts District Attorneys (DAs) anecdotally reported that alleged perpetrators were more likely to plead guilty before trial when the prosecution presented evidence collected by SANEs, which saved prosecution

costs (Massachusetts Department of Public Health, 2007). Examples from the data of positive and negative economic influences were:

- For years I fought having funding an issue, but I think the reality is making sure that the programs support themselves is essential to further development, for further development of programs in the job market there is gonna be more educational programs to meet that demand. (Q12-P20)
- For all that's wrong with the current US administration (2006), they've given more money to victims of violence, than all the previous ones combined. They have provided education for nurses, to the tune that has not seen before. (Q9-P19)

*Sustainability factors.* Sustainability factors had a positive and negative influence on forensic nursing knowledge and educational development. Examples from the data of positive and negative sustainability factors were:

- I think it's resources. I really think - who is available, because it's expensive...finding these specialized people who can teach is challenging. (Q13-P07)
- The main reason why they have been sustained would be the people teaching it. (Q13-P15)
- A couple of programs at universities I know of died because of lack of funding, and lack of faculty. I think it's because when they lose some of their most key resources, they don't have the stimulus to keep moving. There's got to be a key driver. Somebody who's willing to sort of be the martyr of the program. (Q13-P11)
- But a lot of the issues, why they die is that they're one person programs at this point. (Q13-P16)

*Technology advances--CSI effects/phenomenon.* A Dane County judge in Madison, Wisconsin reported that unrealistic expectations were impacting jurors in Dane County. It was called the *CSI effect* (CSI Effect, 2005). Crime officials said the positive side of the CSI phenomenon was that the crime shows have made terms, such as *DNA* household names. However, now jurors want DNA evidence every time (CSI Effect,

2005). The TV showed images of crime and murder and detectives who easily found clues and caught *the bad guy* in 60 minutes, but in real life, when it is time to try the bad guy, it's not quite that simple (CSI Effect). Examples from the data were:

- A real significant factor over the last couple of years, both positive and negative, is the CSI effect. You don't have to educate juries about DNA like you used to, but I mean the reality is we don't have the type of evidence they do on television. (Q11-P20)

*Political influences.* Social policies and emerging social priorities had a positive and negative influence on forensic nursing knowledge and educational development. One example from the data was:

- You can never leave politics and emerging social priorities out of where we seem to find ourselves. (Q2-P10)

#### *Constructed Connotations of Positive/Negative Factors Influencing Theme*

This Positive and Negative theme addressed the most and least satisfying factors in teaching and developing the courses, how organizations fostered or did not fostered educational development, how educational institutions have been supportive or not supportive, facilitating and impeding factors of social, media, technology, economic and political, and sustainability and non sustainability factors of programs. From a constructivism approach, points are mentioned here that are significant to this study.

*Bandwagon effect.* A bandwagon effect occurred in the rise of popularity in the forensic professions, fueled by media attention to the word *forensics* (meaning forensic science or forensic medicine). Media exposure brought a fascination among the public with forensic science, and with all areas of working with victims, offenders, and forensic pathology.

*Media and technology have overshadowed important social movements.* When respondents were asked what social factors influenced the development of the specialty or educational courses, most of them mentioned the current media have created more awareness among the public rather than the many important historical social movements of the 1960s. The movements of human rights, gender and women rights, offender and victim rights, inmate law suits, were not mentioned, but respondents did mention more awareness generally by the public.

#### *Theme 5.6b. Historical Factors Influencing*

Throughout the dataset, the *history* of forensic nursing and forensic nursing education was acknowledged as a significant part of the knowledge development of the specialty (See Table 5.6b. Historical Factors Influencing theme).

Table 5.6b

#### *Theme: Historical Factors Influencing*

<i>History - Need in Society</i>	<i>History – Forensic Subspecialty</i>
<i>Reactive</i> <ul style="list-style-type: none"> <li>• Society need for better care for Victims/ Offenders</li> <li>• Need for medico-legal role</li> </ul>	<ul style="list-style-type: none"> <li>• 1976 –SANE</li> <li>• 1976 - death investigators</li> <li>• 1976 - forensic psychiatric</li> <li>• 1970s - legal nurse consultants</li> </ul>
<i>Proactive</i> <ul style="list-style-type: none"> <li>• Nurses need for better care for Victims/ Offenders</li> </ul>	<ul style="list-style-type: none"> <li>• 1980s - Interpersonal violence</li> <li>• 1990s forensic nurse educators</li> </ul>
<i>History- Educational Development</i>	<i>History – IAFN</i>
<ul style="list-style-type: none"> <li>• Forerunner Courses of Forensic Nursing</li> <li>• Continuing Education Birthplace</li> <li>• 1976-1977 –SANE</li> <li>• 1976 - death investigators</li> <li>• 1976 - Forensic psychiatric</li> <li>• 1989-1990 -1995 educational programs</li> </ul>	<ul style="list-style-type: none"> <li>• Defining Moment</li> <li>• Specialty Status</li> </ul>

### *Literature Comparisons Historical Factors Influencing*

The literature review done for this study (Chapter Two) provided an overview of the history of many of the subspecialties of forensic nursing and the *historic* reasons why forensic nursing and forensic nursing education developed. This theme provides data extracts about the *history* that can be compared to the literature.

*Forerunner courses of forensic nursing.* In the 1980s, with the emphasis in society on victim rights, women rights, human rights, and offender rights, victimology and criminology courses were established. Victimology and criminology courses or programs were the forerunners of forensic nursing programs in many areas. While victimology courses were the forerunners to clinical forensic course and SANE courses, criminology courses were the forerunner to forensic psychiatric/correctional courses. Many nurses who had electives in their basic and advanced programs often took courses like criminology and victimology due to an interest in forensic issues in society and in forensic specific vulnerable populations (Kent-Wilkinson, 2006). Examples in the data were:

- Dr. Anne Burgess did that first victimology course in 1989, 1990 somewhere in there a long time ago. (Q6-P15)
- And I developed a victimology program, which provided comprehensive care to both sexually assaulted patients as well as victims of domestic violence. (Q6-P03)
- You know theories of crime that, and I had taken some criminology before I started to teach, so, understanding those historical antecedents. (Q6-P06)
- Forensic science, forensic psych, criminology courses shaped forensic nursing. (Q6-P11)

*Continuing education departments.* Historically, the Continuing Education Departments of universities were often the birthplace of many specialty educational

courses. With the success of the forensic nursing courses in Continuing Education Department, they began to be placed in the nursing curriculum in many universities.

- It actually was a continuing medical education department. (Q8-P19)
- It was probably the first university approved continuing education course. And that would have been in 1988. And we were teaching residents and nurses about sexual assault, domestic violence, elder abuse, all kinds of stuff. (Q8-P19)
- Initially by having, the CEU programs based there, and then developing courses, and hopefully now developing, whole tracts. (Q10-P20)

*Current educational trends.* In Canada the current trend at the graduate level is nurse practitioner programs, in addition to the advanced practice clinical nurse specialist model with a specific track or focus. To date there is only one elective forensic nursing course at the masters level. In the United States, however there are entire forensic nursing track programs at the graduate and doctorate level with promises of many doctorate nurse practitioner (DNP) programs in the future. Examples from the data were:

- The trend is now, is that virtually every master's forensic nursing in the U.S, is talking about having a doctorate of nursing practice and to me that's gonna change the face of forensic nursing. And I never could have envisioned this ten years ago Arlene. (Q10-P19)
- How have institutions of higher learning supported forensic nursing as a new evolving specialty? Well it actually is done a parallel what's happening with the doctorate of nursing practice in the States. And that is that so many schools are taking their master's programs that are advanced practice programs and turning them into DNP. And forensic nursing is not gonna be any different. It's gonna have to either figure out do they want to be part of this process or not? (Q10-P19)
- So the DNP is gonna change the face of forensic nursing in the future. And there will be master's nurses. And they will be the experts in their arena. But I don't see them as being the leaders. I see the DNP as being the practice leaders. (Q10-P19)
- But the reality is there's over a hundred nursing schools in one year that are converting their nursing, master's programs to the DNP. (Q10-P19)

*History of SANE.* The development of sexual assault nurse examiner (SANE) programs began when healthcare providers realized that the standard of care was inadequate for sexual assault victims in hospital emergency departments. Historically, sexual assault victims were treated by physicians and nurses who had little or no training in forensic evidence collection (Fagan, et al., 2003). Today, this role is performed by specially trained nurses called SANEs who provide comprehensive care to victims of sexual assaults. Examples of data extracts with regard to the history of SANE in the United States were:

- The year that I did my first SANE training program would have been 1977. (Q6-P20)
- I became very concerned about the way that people who were sexually assaulted were treated, not that they were treated badly, but that I felt that we needed to do something else. And I developed a victimology program, which provided comprehensive care to both sexually assaulted patients as well as victims of domestic violence. (Q6-P03)
- So there was an upward pressure if you will, from the communities, many times the SANE programs would be the ones that would start it, and they'd say: I want my school to offer me more education, I don't have the money to go away, I need to be able to do it here. And so, I think that the SANE programs pushed upward and then from the top down the legislation, that governs the programs pushed it that way. (Q11-P19)
- And then you had court decisions that were occurring as nurses testifying, that were also pushing it. (Q11-P19)

Examples of data extracts with regard to the history of SANE in the Canada were:

- In Ontario, we looked at other programs in the US and decided what content they wanted for Ontario. We first started those sexual assault courses, training was in 1995 offered, two times a year. (Q6-P12)
- SANE course was put together through the collaboration of six clinical specialists. (Q6-P12)
- For all SANE course the clinical practicum is required - cannot just take the course have to demonstrate their proficiency. Anybody can sit in a classroom and listen, but whether or not they know how to use it is something else. They have to demonstrate before they start working with,



the sexual assault victim on their own. That they have incorporated everything that they learned in class. The different clinical elements built in to it. (Q6-P12)

- What became different in expanding the role was not having physicians involved cause - that's really one of the issues that started this. (Q6-P12)

*Interpersonal violence forensic nurses.* Historically, health care professionals did not routinely ask patients if they had a history of violence behaviour or if they had ever been abused. They felt “asking the question” was in some way an invasion of privacy, and many did not want to have to take the time to deal with the legal implications of any disclosed information. The role and educational development of clinical forensic nursing occurred in the 1990s when health care systems finally took responsibility for the assessment and prevention of the health of victims of violence. Domestic violence screening was made mandatory in all hospital emergency and admitting departments.

The health care systems in Canada and the United States now accept it as their responsibility to screen, document, care for, and report any traumatic or psychological injury from any interpersonal violence, child/elder abuse and/or neglect, and domestic violence. It is mandatory that all health care professionals now focus on the role and cause of violence, rather than just the patient injury.

In the United States, the Joint Commission on Accreditation of Health Care Organizations (JCAHC) created specific guidelines for nurses, which include procedures for documenting suspected abuse and neglect, collection of forensic specimens, preservation of evidence, procedures for chain-of-custody, processes for photo-documentation, and the course of action for reporting and referral (JCAHO, 2006). An example from the data was:

- Now what has changed is that the government here in the United States, and I don't know what it is like in Canada now, but the government here has mandated that health care workers have no choice but to ask all patients coming into a health care setting, into the ED whether they have been previously or currently a victim of violence, and we also have to assess for on any admissions coming into the hospital, does this have anything to do with violence? But forensic nurses have known that for a long time and have practiced that way, so I think that's why we're unique. (Q5-P17)

*History of death investigators.* When the role of the death investigator was first developed in the mid 1970s, the background training of nursing was determined to be the best preparation for this role (Lynch, 1993b).

- I will always congratulate Dr. Butt because he developed the first program in death investigation, wrote the policy of paying the nurses, an equivalent salary, required them to maintain their nursing license and to be a member of the Canadian Nurses Association. However in America, that didn't happen, for probably 15 or 20 years. (Q11-P08)
- And today, the most, progressive death investigation program in Houston, Texas, has done exactly what Dr. Butt, did in Alberta. I mean they're paid the equivalent salary in clinical and the majority of them are, Master's prepared and those that are not are working on their Master's degree. (Q11-P08)
- There were nurses in Canada, thirty years ago, that were practicing death investigation but it wasn't called forensic nursing. There were nurses doing sexual assault examinations of, that started about the same time the nurses in Canada started doing death investigation but they weren't called. I did in my graduate work which was to identify all of the areas, where nurses worked in a forensic arena, and developed steps, of a discipline, a scientific discipline from all of those areas. (Q6-P08)

*History of International Association of Forensic Nursing, 1992.* The IAFN captured the broad scope of forensic nursing and members experienced the excitement of pioneering this new specialty. The IAFN conference was often a defining moment of change for many attendees. Members realized the broader perspective of forensic nursing

where many areas of practice came under the same umbrella. Examples from the data were:

- The first IAFN conference that I, attended was in Louisville, Kentucky in 1995, the...from there I saw the huge world of forensic nursing. (Q6-P09)
- And I was, I feel into it absolutely with delight because I just...from that point on and all of the above. (Q6-P09)
- First of all, realizing that what I was doing was actually forensic nursing. prior to that, I was strictly focused on the area of sexual assault examination. (Q6-P09)

*Need in society--reactive and progressive roles.* The specialty of forensic nursing evolved just as other specialties of forensic medicine and forensic psychiatry evolved, which was when there was a societal need for a specific medicolegal role. Forensic nursing, however, has been both reactive and progressive in its historical development. Some of the subspecialty roles of forensic nursing developed because nursing saw a need for improved care and felt that the medico legal role could best be filled by nurses with additional specialty education. In this case nurses took a proactive role. In other cases, roles for forensic nursing developed reactively when society demanded that there was a need for a forensic nursing role. A few of the examples present in the data with regard to the *proactive role* of forensic nurses in society were:

- Forensic nursing evolved from the need to increase the care to victims and perpetrators, some from societal need and some from our own need to improve the services. (Q1-P10)
- The increasing concern that I had regarding the need to do more for victims of violence, law enforcement relationships and perpetrator dynamics. (Q1-P03)
- Forensic nursing is a new area of practice that has evolved out of the practice of the sexual assault nurse examiners who first started I think all of the professionals to start to recognize the fact that there is an area of nursing that is specific to forensics. (Q1-P17)

- The key was when nursing educators recognized that this specialty, was one that was needed, but they didn't have an infrastructure to address it. (Q11-P19)

A few of the examples present in the data with regard to the *reactive role* of forensic nurses in society were:

- Seems like we fall into things because people need us to do them, and I think that's kind of what's happened here in forensic nursing too, I think it's only recently that we've really tried to start taking control of it and managing it and defining it and saying this is what we are -whatever. I think it juxtapositions and competes with those traditional ideas that professions get their meaning and their charge, their mandate from society. (Q2-P10)
- Forensic nursing evolved from the need to increase the care to victims and perpetrators, some from societal need and some from our own need to improve the services. (Q1-P10)
- You can never leave politics and emerging social priorities out of where we seem to find ourselves. (Q2-P10)

#### *Constructivism Connotations to Historical Factors Influencing*

Although questions about the history of the development of forensic nursing and forensic nursing education itself were not directly asked in the Interviews, many of the educators provided certain aspects of the historical development when responding to each question, as seen in the data extracts cited in this theme.

##### *Theme 5.6c. Significant Person/Leader as a Influencing Factor*

All participants who were interviewed were leaders in the field of forensic nursing. This theme addressed what the participants said about leadership and their own passion, drive and mission to develop educational courses (See Table 5.6c. Significant Person/Leader)

Table 5.6c.

*Theme: Significant Person/Leader*


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• Forensic Nursing Leaders	• Educator	• Responsibility
• Significant Individuals	Contributions	• Passion/Mission

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*Literature Comparisons to Significant Person/ Leader Theme*

Nursing must provide leadership in influencing the organizational, social, economic, legal, and political factors within the health care system and society. “These and other factors effect the cost, access to, and quality of health care and the vitality of the nursing” (Newman, et al., 1991, p. 2).

Although it was a privilege for forensic nursing educators to develop some of the first forensic nursing and forensic multidisciplinary academic programs internationally, it was also a responsibility. The media played a role in marketing an awareness of the forensic area, but the responsibility of communicating the unique knowledge of the specialty was dependent on the forensic nurse leaders in the field. Articulating the specialization in any discipline is serious, rigorous, and demanding. This task or responsibility requires that the leaders in each of the knowledge professions, beginning with the leaders and scholars in each field, must take on the hard work of defining what they do (Kent-Wilkinson, 2006). Some of the data extracts in this data were:

*Goals*

- My goal at the time was to develop a field in nursing, that paralleled that in the forensic sciences, because every specialty area in the forensic sciences that was related to medicine, had nurses were working in that field but with no recognition, no identification, no labels, and no formal education. (Q13-P08)

- The fact that I did this was the result of the increasing concern that I had regarding the need to do more for victims of violence, law enforcement relationships and perpetrator dynamics. (Q1-P03)

*Directors/ Coordinators (leaders)*

- Forensic nursing is right in the middle at the interface. Forensic nursing are often the directors for many other areas of health care? We're able to provide direction for those victims and to interface with the other areas of forensics or law, with counseling or anything that they may need. (Q2-P05)

*Asked to start program*

- And so that when I was asked to start this program that was really my background, even though I knew, sexual assault nurse examiner (SANE) was a big role for many forensic nurses. (Q6-P17)

*Forensic Nurses as Leaders*

- Forensic nurses also need to be leaders in development of programs. (Q5-P05)
- Well certainly you can't give enough credit to some of the early leaders of the International Association of Forensic Nurses (IAFN), as far as really pushing forensic nursing into mainstream, not only clinical practice, but also pushing it into mainstream academia. (Q9-P16)

*Future Leadership*

- So the DNP is gonna change the face of forensic nursing in the future. And there also will be master's nurses. And they will be the experts in their arena. But I don't see them as being the leaders. I see the DNP as being the practice leaders. (Q9&10-P19)

*Educators Constructed/Created Knowledge*

- Also talking with some of the colleagues who have created programs throughout the country prior to the one I created. (Q2-P16)

*Constructivism Connotation of Significant Person/Leaders Theme*

Knowledge construction and knowledge creation was evidenced by the development of forensic nursing educational courses and programs in Canada, the United States, and in many other developed countries (See Appendix C1). Nurse educators have contributed to the construction of the forensic nursing specialty that is emerging worldwide.

Although there were many *influencing factors* in the development of forensic

nursing knowledge for educational programs, the role of the individual nurses has made a significance difference. Many individual nurses were driven and felt a *mission* and a *passion* to either pioneer a forensic nursing role, and or to develop some of the first forensic nursing educational courses. Examples from the data were:

- Well it's certainly been my *mission* in life, outside of raising my children. (Q13-P08)
- It became something I absolutely *had to do*. (Q13-P09)
- At some point it became a *mission*. (Q13-P19)
- There was a transition, for me and it occurred rather early and I tried to escape it the last time I tried to escape it was in the nineties. (Q13-P19)
- The forensic nursing courses are there and survived because of the few *passionate* people there. (Q9-P15)
- I *pushed* for it for a good five years before they did finally was accepted and promoted. (Q9-P05)
- Why they chose forensic nursing as opposed to a nurse practitioner program in gerontology is because of the *passion* of this sexual assault nurse examiner, faculty member. (Q9-P06)

A significant finding, as previously noted in the descriptive statistics, was that many of the first forensic nursing programs were developed by nurses who were not doctoral prepared and were not on faculty at the time. Yet, these forensic nurses managed to have their courses or programs entered into curriculum at major colleges and universities. One participant in this study was baccalaureate prepared. This achievement speaks to the passion, drive, and determination of individual nurses who felt compelled by their mission to make forensic nursing education a reality.

#### Summary of Chapter Five

In Chapter Five, I presented the main knowledge themes in exploring the knowledge of forensic nursing and factors influencing educational development. In the findings section I provided the theoretical scheme, where segments of actual data

provided useful explanatory material to support the knowledge themes when compared to the relevant literature for this study. I used a constructivist approach to help interpret the data into the knowledge themes of: delineation of knowledge, differentiation of knowledge, needed knowledge, unique knowledge, and definition of knowledge. In each knowledge theme, the findings showed that knowledge was not an *either/or* perspective but rather that *both/and* or multiple perspectives were more likely to be the case.

A definition of forensic nursing was constructed from relevant data of each knowledge theme, and employed the constructivism language of *not only/but also*, *both/and* and *it depends*. In addition, a summary of the theoretical models used in forensic nursing education was compiled, and an interdisciplinary practice model, with social justice as an overarching theory was constructed.

A constructivist approach also helped me to interpret the influencing factors theme of knowledge development as *it depends* was evident in the multiple factors that influenced educational development. The multiple factors were represented by the social/media/economical/technical, and political factors, in addition to the satisfaction and sustainability factors. Both positive and negative accounts influenced educational development and both were important.



## CHAPTER SIX

### DISCUSSION, IMPLICATIONS AND CONCLUSION

In Chapter Six, I revisited the choice of study topic, the chosen methodology, and the paradigm for this study. In the *discussion* section I identified issues that arose from the data in terms of questions that forensic nurse educators stated they struggled with in their educational course development of forensic nursing. In the *implications* section I addressed implications for theory, practice, education, and future research. The *key findings* or *outcomes* of the study were cited along with a *conclusion*, that together answered the main research questions of this forensic nursing education study.

#### *Choice of Study Topic Revisited*

I was interested in exploring forensic nursing knowledge as a specialty area of study due to the opportunity I had to write and teach forensic nursing courses beginning in the mid 1990s. Although it was a privilege to construct some of the initial forensic nursing courses, it was also a responsibility. Without a template of previous forensic nursing courses or programs in existence, I found it a challenge, not only to decipher the knowledge elements to include, but also a challenge to frame the courses conceptually. Now that there are a number of programs established in North America and around the world, I thought it was timely to explore forensic nursing knowledge from the multiple perspectives of other educators as to its definition, conceptualization, philosophical base, and unique knowledge. I also wanted to investigate factors that have influenced educational development. This two part query became the main research question of my doctoral dissertation.

### *Choice of Methodology Revisited*

Once I began my doctoral study, and determined my research questions, the next question became: what was the best way to investigate my research problem? Which methodology should I use to answer my research questions? Because I wanted to both explore and explain phenomena, I chose a mixed method exploratory study, with a constructivism approach. A thematic analysis of interview data interpreted from a constructivist worldview presented an appropriate method for generating explanations of phenomena that are directly relevant for this focus of study.

This kind of research answered questions about why social processes worked the way they did and helped to describe and explain experiences of the participants. I used a thematic analysis method for identifying, analyzing, and reporting patterns (themes) within data. I minimally organized and described my data set in (rich) detail. However, as is frequently the case with thematic analysis, I went further in my study, and interpreted various aspects of the research topic.

In the *Knowledge* themes, beginning with the *Knowledge Delineated* theme where I was counting frequencies of concepts, I believe I was beginning to do a content analysis, and then in describing the concept of forensic nursing, I believe I was advancing into elements of a concept analysis. Walker and Advant (1995) defined a concept analysis as a strategy to define the attributes of a concept; a rigorous process to determine a tentative product. The purposes of doing a concept analysis are to distinguish between the attributes of a concept and its irrelevant attributes. Concept analysis refines ambiguous attributes in theory and it examines information prior to research and theory building

activities. The defining characteristics or critical attributes of a concept analysis, according to Walker and Advant (1995) are that it “serves to cluster attributes most commonly associated with the concepts, it also functions to make differential diagnosis, and helps to differentiate the concepts from ones similar to, or related to it” (p. 41). The *Knowledge Differential* theme showed the difference between forensic concepts and I believe in this area I went further than a thematic analysis.

#### *Constructivist Paradigm Approach Revisited*

Constructivists believe that knowledge is essentially subjective in nature, constructed from perceptions and mutually agreed upon conventions. According to this view, new knowledge is constructed, rather than simply acquired by memorization or through transmission from those who know to those who do not know. Meaning is constructed by assimilating information, relating it to existing knowledge, and cognitively processing it (Bates & Poole, 2003). For the interpretation of data in this forensic nursing educational study, Dewey’s (1933, 1938) early principles of constructivism seemed to fit because much of the participants’ responses were phrased using the terms of *not only/but also*, *both/and*, *a combination of* and *more likely to* and *it depends* or *influenced by*. For each theme I identified in this study, I attempted a constructivist world view interpretation of the analysis in the findings.

#### *Discussion*

As awareness of a forensic specialty became known, students began to ask for courses in the area and wanted to know how they could become a forensic nurse? As forensic nursing rapidly appeared in curriculums of many leading colleges and

universities around the turn of the 21st century, forensic nurse educators themselves had questions about different aspects of the forensic nursing specialty. The following topics were questions participants in the study stated they struggled with:

*Discussion Questions*

- *How and What to Teach*
- *Forensic Nursing a Unique Specialty*
- *Constituent Parts of Forensic Nursing Knowledge*
- *Clarity of the Terms: Specialty & Discipline*
- *Why Some Specialties Advance*
- *Caring Paradigm*
- *Unique Knowledge (Dual Knowledge)*
- *Influences of Partnerships and Affiliation Agreements*

*How and What to Teach*

“How do we best organize and disseminate this unique body of knowledge?”

“What content should be included in each course or program of study?” Perhaps, the most important question educators had was: “Are we conceptualizing forensic nursing consistently locally, nationally, and internationally?” (Kent-Wilkinson, 2006, p. 782).

Questions forensic nurse educators struggled with in the educational development of forensic nursing were evident in the data of this study:

- To me the unique knowledge is emerging, and I struggle with, not only how to teach, but also what to teach. And for me that’s evolving. I think that there is a lot, what makes the knowledge unique. (Q5-P10)
- And we had to seek our own level of what we thought was appropriate, I myself battle with that because, usually in a discipline you’re lucky enough to have some core curriculum already established or at least a skeleton of an idea of what needs to be taught. (Q10-P11)

In this study of forensic nursing education I hoped to present some consensus or understanding as to common questions from the collective perceptions of forensic nursing educators in the two countries. The findings of this study provided the collective

perspectives of forensic nursing educators that were analyzed thematically into the knowledge themes resulting in the beginning work for constructed definitions, a framework for an interdisciplinary forensic educational model, and a forensic meta-theory.

### *Forensic Nursing a Unique Specialty*

Is forensic nursing a unique specialty, or is it nursing applied to a special population of victims and offenders with nursing working in those environments? Participants in this study struggled with this query and this question has been debated in the literature. Mason and Carton (2002) noted that in forensic nursing, debate is centered on two points: whether generalist principles of professional working practices are merely being applied to a specific patient population; and, whether there is a unique body of knowledge known as *forensic*. This debate was evident in the following extract from the data:

- I struggle sometimes with- - is forensic nursing a unique specialty area or is it nursing applied to a specialty population, or a special environment. (Q1-P01)

From a constructivist perspective, forensic nursing may be both a recognized specialty area, and nursing applied to a specialty population or a special environment. Forensic nursing has also been recognized as a specialty area by the American Nurses Association in 1995 (ANA, 1995).

- The American Academy of Forensic Sciences was the very first, even before nursing, to recognize forensic nursing as the scientific discipline. That was in 1991. (Q9-P08)
- And then finally the American Nurses Association has, in 1995 when they ...acknowledged forensic nursing as a specialty not a sub-specialty, that gave some political justification to this as a specialty. (Q9-P16)

- ❖ Forensic nursing is both a unique specialty area, and it is nursing applied to a specialty population, or a special environment.

### *Constituent Parts of Forensic Nursing Knowledge*

One of the most arduous undertakings of this study was my attempt to establish what was unique about forensic nursing knowledge. In the analysis, I found 92 prefix words that the term *forensic* was attached to, and discussed the usages and origins of the words *forensic* and *forensics*. However, this proved not to be a significant finding of the study.

Mason (2002) advised that nursing should be more concerned with the constitutive parts of our knowledge base rather than the derivation of the word *forensic*. “The quest for forensic nursing as it is for the other forensic disciplines is to establish their unique knowledge for working with their patient groups” (p. 512). This warning by Mason was an inspiration for my forensic nursing educational study. It clarified for me that although my discussion may have been interesting on *forensics* as a noun, and a new word or term in postmodern society, along with my 92 examples of forensic prefixes, it was not by any means the most important reason for or findings of my study. Rather, more important were the findings of the created or constructed definition of forensic nursing, and the differentiation of forensic nursing, when comparing forensic nursing knowledge to nursing knowledge in general, and when comparing this knowledge to other forensic disciplines on the multidisciplinary team.

The constituent parts of forensic nursing knowledge became the themes of: knowledge delineation, knowledge needed, knowledge differentiation, and knowledge

defined. I recognized early in the study that the *unique* knowledge needed to be divided into elements that meant different and needed, and that the special unique knowledge of forensic nursing was the *dual* and *needed* knowledge and roles which were different from both nursing in general and different from other forensic disciplines.

#### *Clarity of the Terms: Specialty and Discipline*

Findings of this study may initiate discussion about joined or joint specialties. Educational administration, nursing administration, educational technology, nursing informatics are some examples where one might question--from which side are the theoretical underpinnings based? A key question in forensic nursing is, Do the philosophical underpinnings adhere to nursing or to forensic(s)? If the two philosophies conflict, what are the implications for practice? Does the unique knowledge come from forensic or from nursing? Are all new dual or focus specialty areas faced with the problem of which theoretical foundation to adhere to?

The literature review of this study explored the terms of *forensic* and *forensics* and the *forensic prefix* as an adjective and *forensics* as a noun were explored as a typology in the findings. A question for discussion: Is the term *forensic* remaining as an adjective to describe a specific professional specialty? Or is *forensics* becoming a new postmodern discipline, with its media promotion, unique language, cryptic roles, and enthusiastic following of *CSI wannabe*'s, but lacking a professional theoretical base? Is *forensics* overshadowing the professions or disciplines? At this point, *forensic* is a focus area of knowledge, more similar to a focus area like *geriatrics*, which is a focus area for many professional health care disciplines. Is *forensics* emerging as it own discipline like

law, nursing, medicine, psychology, or psychiatry. Of interest *dietetics*, once a focus specialty area of nursing did become a discipline or a specialty of its own.

This discussion may help future educators (who are beginning to develop courses and to provide forensic nursing) become clear as to forensic nursing's foundational base. I hope to make clear that forensic nursing is not a joint specialty, nor a dual specialty, but rather it is a specialty area of nursing, and as such has nursing as its disciplinary base.

Constructed statements from this study as to what forensic nursing *is not* are:

- ❖ A specialty in nursing is forensic, NOT a nursing specialty in forensics.
- ❖ Forensic nursing is a nursing specialty with a forensic focus within the discipline of nursing; forensic nursing is not a specialty of the discipline of forensics, because forensics has no disciplinary base.

Although *forensic* may describe the specialty part of the knowledge, *nursing* is the discipline and the ideological base. There was consensus from the participants that nursing is the foundational base of forensic nursing, and should be the foundational base of forensic nursing programs. Nurse educators need to be clear of their terms when teaching, in regard to *what a discipline is* and *what a specialty is*. The discipline is *nursing* and the specialty is *forensic nursing*. Forensic nursing is not a discipline, but rather is a specialty of nursing. Clarity is needed between the terms *specialty* and *discipline*.

#### *Why Some Specialties Advance*

A question of interest in this study was why some specialties advance to where they have advanced practice levels of education, and others did not? Specialties in nursing have been thought to mature (if they mature) by a process of phases. Hanson and Hamric



(2003) believed that “each of these phases is part of the natural evolution toward advance practice nursing that occurs as a practice specialty matures” (p. 203).

Advanced practice requires that the base discipline has advanced itself to a graduate level with all the processes in place so that focus specialty tracks or focused specialty programs can be developed by qualified faculty with specialty expertise. *Specialty* education is based on successful strategies that improve client outcomes and are derived from a combination of various sources of evidence, including student perspective, educator perspective, research, national guidelines, policies, consensus statements, expert opinion, and quality improvement data (Canadian Health Services Research Foundation [CHSRF], 2005).

However, not all specialties evolve into advanced practice nursing, so this is not an inevitable progression, for example *dietetics* was an early nursing specialty that matured into a separate discipline. Some specialties have evolved away from clinical practice as a central defining focus (i.e., *nursing administration*). As hospitals grew in complexity, the knowledge base needed for effective management became organizational and business knowledge. The focus of nursing administrative practice is now on the nursing workforce and the management process within organizations, rather than on clinically based practice with patients and their families (Hanson & Hamric, 2003).

In a like manner, nurses in the continuing education and staff development areas have identified a number of competencies for their unique specialty, that are distinct from the advanced practice nursing (APN) competencies (National Nursing Staff Development Organization, as cited in Hanson & Hamric, 2003). “It is not always clear whether a

given specialty in nursing will evolve into an advanced practice nursing role” (Hanson & Hamric, 2003, p. 204). It remains to be seen whether specialties in the first two phases, such as parish nursing, will evolve into a APN-level specialty.

Forensic nursing is often taught as a certificate program after the basic nursing program, or at the post graduate level where the core fundamentals of nursing are already established. There is a movement in education in both countries to bring certificate programs into the graduate level. Forensic nursing has evolved to the advanced practice level and now has masters and doctoral tracks in education at many universities. The reasons may have been that (a) nursing as an academic discipline already had the infrastructure in place for advanced practice education, and (b) the multidisciplinary nature and popularity of the forensic specialty made it timely to advance its status. I made the following assumptions with regard to advanced practice forensic nursing and specialty education when reflecting on the nursing literature in both these areas:

- ❖ There is a movement of specialty education to the graduate level.
- ❖ Advanced practice is at the graduate level.
- ❖ Advanced practice nursing is nursing.
- ❖ Advanced practice forensic nursing occurs at the graduate level at the clinical legal interface.
- ❖ The specialty is forensic nursing, but the discipline is nursing.
- ❖ Specialty education may be taught interprofessionally at the graduate level as the foundations for each discipline are already taught at the undergraduate level.

From the above assumptions, the following definition of advanced practice forensic nursing education was constructed:

- ❖ Advanced practice forensic nursing (APFN) occurs at the clinical legal interface at the graduate level. The specialty education of forensic nursing may be taught interdisciplinary or interprofessionally because the

foundation for each discipline has already been taught at the undergraduate level.

### *Caring Paradigm*

Nursing has long claimed that *care* is a core component of nursing, but is the caring paradigm specific or exclusive to nursing? “Through ‘caring’, professional nurses enact the ‘uniqueness’ of nursing and their conviction that nursing practice can make a difference in the health of individuals, families, aggregates or cultures” (Newman, et al., 1991, p. 2). Mason (2002) noted that “nursing has not established a monopoly, nor should it, on the forensic therapeutic activity as many other disciplines also lay claim to this” (p. 512). For example, probation officers, social workers, advocacy groups, counselors, community workers and volunteer agencies, also claim a forensic therapeutic interest. The following extract recognizes this point:

- Although I do recognize that nursing isn’t the only discipline that calls itself a caring discipline. But I mean that has been our contribution in many regards. But it’s unique. (Q5-P01)

The philosophy of nursing is often defined as caring and the human health experience. Therefore, forensic nursing can be defined as caring for the human health experience with respect to violence in society. One example from the data extracts was:

- That caring philosophy permeates not just the courses but the programs and indeed for me, what I think nursing is. And if they’re not all the same, then I think that’s where we get into trouble, in terms of education. (Q3-P10)

The findings of this study validated that nursing’s caring paradigm was different from other disciplines in that it was more likely to involve a social sense for the *continuous 24/7/365* nature of the caring therapeutic role of the nurse, and an extension of that role to the family and community. Robinson and Kettles (1998) found that one of

the differences between forensic nursing and other forensic disciplines was the provision of care to this complex and challenging group of patients 24 hours and day and 365 days a year. The following data extracts from this study describe the specific elements of *care* that nursing can claim as different from other disciplines:

- Forensic nurses are different because we are taking care of individuals that are victims of either violent acts or traumatic occurrences all the time, whereas nurses in the general population may take care of those same types of victims but not on a continuous basis. (Q5-P05)
- Where most of the time in the rest of forensic science you really don't have that, you're operating on a victim, or a suspect, or a known offender, and you don't tend to have a social sense of continuity of care, having any sort of a need, or a responsibility for ensuring some sort of a therapeutic contact is maintained with the person. It may not be the forensic nurse, himself or herself doing this, but it's part of our responsibility to ensure that those social processes are fully integrated. (Q5-P11)
- Forensic nurses have a cross-over between responsibility for the living victim and their extended, human contacts. (Q5-P11)

#### *Unique Knowledge of Forensic Nursing (Dual Roles)*

In determining what was unique about forensic nursing knowledge, the literature in the forensic psychiatric arena has often asserted that *custody and caring* are unique to this area. Mason and Carton (2002) stated, “this one point of uniqueness, although difficult to define, is highlighted in the literature as the contrasting aims of caring and custody, in the disparate nature of the inchoate profession” (p. 550).

Unique, too, in that it comes with at least two roles that have conflicting ideologies for the nurse who is charged with balancing the two. “Within secure psychiatric settings, they must provide care for and maintain custody of these patients, a paradoxical role that makes this type of nursing unique” (Gudgeon, 2004). Sekula, et al.,

(2001), contended that the discourse on forensic nursing produces a form of knowledge in which patients need *care* as well as *custody*.

This study supports Mason and Carton (2002) belief that what was unique about forensic nursing was the dual role of *custody and caring*. In their study the dual roles applied to only one area of forensic nursing (i.e., the forensic psychiatric/ correctional nurse). This study, in addition, addressed other forensic nursing subspecialties, and found that each subspecialty had its own dual roles that often were paradoxical. However, both were necessary and equally important to the role (e.g., care and evidence collection, care and chain of custody, care and crisis intervention, or care and court testimony).

The literature in other subspecialties of forensic nursing also spoke to the challenge of dual roles. “SANEs reported experiencing dilemmas with respect to their dual roles as caregivers and evidence collectors” (Du Mont & Parnis, 2003, p. 173). In this study I found that the *dual roles* or *dual knowledge* was the *unique knowledge* because the dual roles were what was different or unique from both nursing in general and different from other forensic disciplines.

In this study I alluded to the possibility that the knowledge that was different from nursing and forensic nursing was the *forensic knowledge* and the knowledge that was different from forensic nursing and other forensic disciplines was the *nursing knowledge*. Therefore, one may conclude that the dual roles may be unique or different to both. Subsequently, unique to forensic nursing is *caring*, together with a matching forensic role unique to each subspecialty could be (e.g., care and custody, care and collection of evidence, or care and court room testimony). Not a dichotomy of one or the

other, but *both/and*, together they may comprise the uniqueness of this specialty. The following data extracts provided evidence of forensic nursing's dual roles with *caring*.

*Caring and Custody*

- Facilitating students in their struggles to come to terms with their dual roles, and the “ah hah” that occurs when they recognize how easy it might be to abandon their nursing roles, and be co-opted by the custodial system. (Q8-P01)

*Care and Court Room Testimony*

- Today nurses are uniquely qualified to testify in court about the consequences of violence because so many physical and mental illnesses and injuries from criminal acts require first the care of nurses. Previously, this was not considered to be in the purview of nursing. (Q5-P08)

*Care and Crisis Intervention*

- Forensic nursing has not only forensic skills, but also the crisis intervention, being able to inform people of their choices and providing the appropriate health care have all proven to be beneficial. (Q11-P12)

*Health care and Healing*

- I think the unique knowledge of forensic nursing is that higher level evidence for how do we promote health and healing through a caring paradigm. (Q5-P10)

*Constructed*

- ❖ *Care* is a core component of nursing. A dual role with *care* is the core component and unique forensic nursing knowledge.

*Influences of Partnerships and Affiliation Agreements*

Partnerships and affiliations have influenced how courses have developed in that the forensic parameters or conceptualizations may be already established. A hazard of any inductive method such as the constructivist approach, according to Charmaz (2000) is an over-emphasis on the individual. The constructivist approach leads to a style that emphasized the views of each active, reflective, participant. Yet larger social forces also act upon this participant so the researcher needs to learn how these social forces affect the participant and what, if anything, the participant thinks, feels, and does about them (Charmaz). For example, in this study, it may be that an educator was contracted to write

a course and was required to write the content with a particular focus. Collaborative or affiliation agreements may have required the course to be written from a special focus. The course or program may be offered in another college or discipline other than nursing for the reasons of a collaborative agreement or as a way of getting the course accepted into a curriculum at all.

The forensic focus as a popular new trend in the 10 to 15 years for courses attracted interest for institutions to develop courses, whether or not they had the faculty with the expertise to do so. Whether the educator writing the course had limited or extensive background experience will have had an impact on the focus of the forensic educational end product. Some participants stated that their program philosophy was influenced by affiliation agreements and unique partnerships as to how and what courses were developed. Examples from the data were:

- Because of our unique affiliation agreement with, and our unique circumstance in our city where we have an affiliation agreement with a federal psychiatric facility, in many ways the forensic parameters were already outlined for us. (Q2-P01)
- Focused on this goal, and that was to collaborate with the School of Law, so that our students would get a clear understanding of the law and from many different perspectives. (Q2-P17)
- ❖ Partnerships and affiliations have influenced how courses have developed in that the forensic parameters or conceptualizations may have been already established.

#### *Implications for Theory, Practice, Education and Future Research*

In this section I address the implications for theory, practice, education, and future research. The literature and the data of this study indicate there have been benefits of having forensic nursing education and what the implications of these benefits have been.

### *Implications for Theory*

The relationship of theory to existing knowledge and the implication of the theory for future research and practice is eminent. Not only is there a need for more forensic nursing programs, there is a need for a forensic nursing educational framework to promote standardization and program structure. This framework should emphasize global concepts within the forensic nursing curricula. Because forensic nursing was a relatively new specialty, there had been limited research regarding development of models specifically designed for forensic nursing education. Utilization of educational models would provide the needed framework not only for theoretical education, but for practical applications in the clinical training area.

*Models and frameworks.* Knowledge development in nursing had to await the introduction of theories and philosophies of nursing in the 1950s. Today there is theoretical pluralism in nursing. A key question now becomes: Are forensic nurse educators basing their ideology of forensic nursing practice on the four central components of nursing's metaparadigm: person, society, health, and nursing? Or are they basing it upon the apparent but superficial discipline of *forensics*? The essential framework and ideology of forensic nursing is *nursing* and not *forensic*. "The theoretical practice model of forensic nursing is based on the integration of forensic science, criminal justice, and nursing science in a unique application of the nursing process to legal proceedings (Bell & Benak, 2001). In this study, forensic nursing educators cited the following as their views on what models or frameworks have guided their forensic (nursing) educational program:



- *Advanced Practice Forensic Nursing Model*
- *Expanded Nursing Practice Model*
- *Multidisciplinary Practice Model*
- *Nursing Framework with Forensic Science Extension*
- *Population Health Model*
- *Public Health Model*
- *WHEEL (wounding, healing, evidence, ethic, and legal)*
- *(Forensic) Nursing Process*
- *(Forensic) Nursing Paradigm*

*Forensic nursing model.* Throughout the database, different frameworks or models were mentioned by the participants as to approaches that from their perspective would be an applicable framework or model for forensic nursing. Each of the models and frameworks cited individually, and in combination have been applied to forensic nursing and have been effective frameworks. In addition, the nursing paradigm and the nursing process as described in a separate section in this chapter would be applicable. From the findings of this study, the following statement can be said about forensic nursing theory:

- ❖ Forensic nursing blends the components of nursing's caring paradigm and a multidisciplinary practice model within a public health framework, under an overarching theory (philosophy) of social justice. Forensic nursing is a combination of the nursing process with elements of the scientific process, the legal process, and a public health approach. Forensic nursing encompasses the nursing paradigm with its own unique definitions of person, health, environment and nursing.

*Social justice.* The practice of forensic nursing fits the basic principles of *social justice* which was simply defined as the concept of a *just society* and a *healthy community*. *Social justice* is an option that could be used as an overarching or meta framework or theory for forensic nursing and forensic nursing education, which could encompass many mid-range theories. The following statements about *social justice* were constructed:

- ❖ Social justice is a thread that weaves through forensic nursing and forensic nursing educational programs
- ❖ Societal norms and societal expectations have an impact on how care is provided for vulnerable groups.
- ❖ Justice is equally important for the perpetrators of violent crime, or offenses, as it is for victims.
- ❖ Societal norms influence the care and treatment of victims and offenders.
- ❖ The social determinants of health can positively and negatively influence the health of the forensic client (victim or offender).
- ❖ Intersectoral approaches that bring together justice, law, social services, education, and health care, are deemed necessary to address the complexity of issues facing the forensic client.

### *Implications for Practice*

Data extracts from this study and the related literature provide evidence for positive benefits as a direct outcome of forensic nursing education. Some of the benefits were: improvements in patient care, changes in attitudes, changes to practice roles, expanded roles, and higher conviction rates. Examples from the data were:

- The patient is benefiting so I would say that is the most satisfying thing and the care is better. (Q8-P07)
- The service to sexual assault victims is better, same with domestic violence. (Q11-P12)
- Many students come into the program with an attitude that I don't want to have anything to do with those perpetrators, I'm all for victims, victims, victims. We really see a fascinating process, as a number of students who came in with very loudly voiced feelings, many of them sexual assault nurse examiners, end up working with and caring for perpetrators. (Q5-P06)
- Assessment of the role of violence in the hospital admission is something forensic nurses have always done. Now it is becoming mandated as standard practice for all health care professionals, that they must assess for history of violence and assess if injury is due to violence. (Q5-P19)

*Expanded practice roles.* There are now specific roles for forensic clinical nurse specialists in many health care organizations. In addition, when one subspecialty of forensic nursing (sexual assault nurse examiners SANE) expanded their role, what

became different was the role of the physician was no longer involved in providing the sexual assault examination. In the case of another model, the Sexual Assault Response Team SART, however, the physician is still involved. Examples from the data were:

- Their role within the agency, or hospital or clinic they work in has been expanded because of their forensic knowledge. (Q8-P03)
- What became different in expanding the role was not having physicians involved, because that's really one of the issues that started this. (Q6-P12)

*Higher conviction rates and assurance of essential intervention.* Many states and provinces have recorded the value of sexual assault nurse examiner programs to essential interventions for patients, higher conviction rates of offenders and savings of prosecution costs. For example, the Massachusetts's Department of Public Health (2007) reported: evidence collection by SANEs compared to non SANEs, along with SANE testimony were important elements in achieving convictions in all of the cases. The SANEs delivered coordinated, expert forensic and medical care necessary to increase successful prosecution of sex offenders, and assured essential medical intervention to victims of assault.

*Need for a framework for analysis of forensic nursing role.* One participant suggested that what was needed was the establishment of a mechanism to determine what a nursing role was, and what a nursing role was not. The following example illustrated this important point:

- Some kind of framework for the analysis of our nursing role, I think is important cause when new roles are emerging, you need to constantly be looking at them and saying is it nursing just because a nurse is doing it, or are there other things that must be incorporated for it to be nursing? And then those options, roles, socialization, and competency. (Q2-P10)

Over the period that forensic nursing as a specialty was emerging and evolving, a

role struggle was apparent, which is common with all new specialty areas, until the roles become identified and understood. Examples of data extracts are:

- Forensic nursing incorporates intrinsic values of caring and health promotion and advocacy embedded in nursing. It competes with other roles that implement forensic science that happens to be occupied by nursing. (Q1-P10)
- The police would say “So why don’t you just be the nurse, and I let me be the cop” Why are you trying to be the cop?” So we had a bit of resistance initially – but not now. (Q9-P03)
- This whole forensic role was something typically assigned to a physician, because they assumed it required a physician with not any basis for it. (Q9&10-P12)
- When I was first exposed to this area I thought I was looking at nurses doing things that possibly might not be nursing. Then I came full circle, and thought no, there is a whole knowledge base there in the clinical areas that is nursing science and is being applied. We just don’t have maybe the research and the writing to support it. But I knew it was there and about to emerge. (Q2-P10)

*Framework for role assessment.* The Scope and Standards of Practice for Nursing, and the Scope and Standards of Practice for Forensic Nursing (ANA, 1997) have already been established, approved, and are updated on a regular basis. Together, with the nursing process and the nursing paradigm, they serve as a mechanism or a framework to guide understanding of nursing roles and nursing specialty roles. I initiated in this study, the groundwork for a paper on the *forensic nursing process* and the *forensic nursing paradigm*. Data extracts from this study provided evidence for a forensic perspective to the important nursing *pentology* of the *nursing process* and the *tetrolgy* of the *nursing paradigm*:

- Forensic nursing is a combination of the nursing process and the scientific process. (Q5-P11).

- We wanted to ensure, that we were preparing nurses, to operate from a framework where forensic science was a natural extending part of the nursing process. (Q3-P11)
- How we define the human being, environment, nursing, and health differently, or different words that we come across when we look at forensic, so we looked at the nursing paradigm. (Q2-P10)

### *Implications for Education*

The recent trend toward and interest in forensic subject matter in the media, due to the increased attention to violence in our society, and media exposure of high profile cases, has all benefited the forensic behavioural sciences. The current fascination with and heightened interest into the understanding of the mind of infamous perpetrators and the social/legal issues of how to deal with such offenders, are issues that are forefront.

This consummation of forensic interest has overlapped into practice, as forensic facilities suddenly seem in vogue as preferred areas to work by health care professionals, resulting in a need for specialty education. Social, media, technology, economic, and political factors have influenced educational development both in positive and negative ways. Students in the behavioural sciences are requesting practicum experiences in the forensic areas and inclusion of forensic content in their curriculum of study. Forensic courses are beginning to be developed to meet this demand in education.

*Challenge and responsibility.* When education in a new practice specialty evolves, the responsibility to articulate the knowledge base falls to leaders in the field. This knowledge is constructed over time and disseminated through scholarly publications, research, and education. As forensic nursing, a new educational specialty evolved, it was a challenge for individual educators to integrate into educational curriculums an epistemology that explained the unique knowledge of this new forensic nursing specialty.

It was also a challenge to articulate the philosophy of this complex practice, develop and define the therapeutic roles, identify the core beliefs, and contribute to expanding body of knowledge for the promotion of quality care in this specialized area of forensic nursing that covered many forensic nursing subspecialties.

In new specialty course development, educators must identify what the unique knowledge is, drawing from whatever resources they have available at the time (i.e., personal clinical experience, educational experience, scholarly publications, and research to date on the elements of this developing specialty). While some new specialties are discipline specific or reflect fleeting trends of short duration, others have roles that cross many disciplinary lines and grow over time to where they acquire specialty status with educational courses at all levels.

*Interprofessional education.* A body of forensic knowledge has been developing as specialties in forensic nursing, forensic psychology, forensic psychiatry, forensic medicine, forensic science, and other forensic disciplines has been evolving. Each discipline has been carving out their unique body of knowledge. With the trend to interprofessional education, specialties that cross disciplinary borders like forensic nursing are well suited; but it is even more important that the unique roles and focuses of the different disciplines be demarcated. I purport that research findings in specialty focus areas like *forensic* that cross many disciplines can more clearly distinguish the specific knowledge that is similar and different to each specialty and discipline. The constructed *definitions of forensic nursing, the interprofessional educational practice model, and the*

suggested *meta-theory of social justice*, for forensic nursing and forensic nursing education, all have direct implications for interprofessional education.

The Centre for the Advancement of Interprofessional Education (CAIE) defined interprofessional education as occasions when two or more health care professionals learn with, from, and about each other to improve collaboration and the quality of care (CAIE, 1997). The intent is to change the culture of health care from one of professional silos to a model that facilitates and encourages teams of health care professionals who collaborate in the spirit of equality to provide superior care (Herbert, 2005). Brooker and Whyte (2000) in a report aimed at multidisciplinary team-working in secure psychiatric settings argued that interprofessional training should take place at the clinical interface. They also added that it should focus on client-centered, problem-based learning exercises that allow for reflexive learning.

There is an educational curriculum trend in universities today toward interprofessional education. Stated objectives in integrated plans at some universities are to increase the interprofessional/interdisciplinary content in curricula of health science programs and to focus on the relationship between education, research, science and communities in an interdisciplinary manner (University of Saskatchewan, 2007b). Annis (2006) purported that nurses in caring for patients and their families believe that interprofessional education and team-work improves patient safety and well-being. Goals are to build collaborative practices, increase professional awareness of knowledge, trust, respect for themselves and others.

*Interprofessional educational practice model.* Multiple data extracts from this study support an interprofessional educational practice model, from which the following model was constructed:

- ❖ Forensic nursing is an area where intersectoral and interdisciplinary collaboration is critical. The forensic specialty is not constrained to only one discipline. No one discipline and no one sector in society can solve the unique and complex problems that the forensic client presents with. Intersectoral approaches that bring together justice, law, social services, education, and health care are deemed necessary to address the complexity of issues facing the forensic client. An interprofessional or multidisciplinary practice model requires liaisons between and among not only nursing, law enforcement and criminal justice, but also colleagues from other forensic disciplines such as forensic science, forensic medicine and forensic psychiatry throughout the criminal and civil legal systems, and/or the medical examiner or coroner systems. The forensic team is a collaborative group of professionals with the mutual goal to help each particular victim or perpetrator. A major objective of forensic nursing is to understand the roles of other disciplines on the team and to work with other disciplines, not in an adverse position with them, when dealing with the client. The collaborative nature of forensic nursing practice is a significant component of the forensic multidisciplinary team.

*Need for consensus on course content.* Some of the participants stated they would be interested to hear the perspectives of other educators with regard to questions raised in this study; particularly the thought was there should be consistency in conceptualization, philosophy, and the concepts that were taught. As example of an extract from the data is:

- I would find it interesting as you talk to other programs, meaning the faculty from different places, to see if we are teaching basically the same content in the introductory or the fundamental type of a course. That might be an important finding and if we're teaching apples and oranges around North America, well maybe one of the things we would need to look at is having some sort of strategies so we're all teaching apples. A recommendation that I have is that this study develop a typology strategy accreditation policy so that everyone is teaching apples. (Q10-P16)



*Recommended--taxonomy knowledge concepts to include.* This study contains within it a taxonomy of the *Concepts to Include* in forensic nursing education and a consensus of how forensic nursing has been conceptualized to date by educators who wrote some of the seminal programs in Canada and the United States (the two countries involved in this study). The taxonomy could be a guide for educators starting and evaluating their own forensic nursing programs or may serve as a foundation for work on core curriculum. See Chapter Five, *Knowledge Concepts to Include* taxonomy developed from this study.

- ❖ Forensic nursing incorporates concepts from both the forensic sciences and the forensic behavioral sciences, as a repertoire of skills is needed in both domains.

#### *Implications for Research*

This study helped to identify what in fact was unique knowledge to this area (dual knowledge or roles) and what knowledge was different from other forensic disciplines (differential knowledge). The differences are important for interprofessional education.

*Definitions.* A variety of definitions of forensic nursing had previously been developed by individuals and groups of members in professional associations. These constructed definitions may be the first time definitions for forensic nursing have been created from the findings of a research study. Research-based definitions were one important contribution of this study, because they validated prior definitions developed by individuals and associations by non-researchable methods during the period of the evolution of the specialty. The definition included similar concepts from other

definitions, but may have provided a clearer description of what forensic nursing was and was not by a delineation of the differential and unique knowledge of the specialty.

*Future research.* In the process of the literature review for this study, I noted that the history of forensic nursing and the history of forensic nursing education could be a study on its own. Also, a future study on forensic nursing education could include more countries because there are known programs in every other continent now, developed in the last few years. If the study was extended to more countries it would allow for greater generalizability. Although a taxonomy was developed on *Concepts to Include* in this study, a future study could attempt to determine the priority of the concepts. The following points summarized the recommendations for future research needed:

- Future study on weight of the *core concepts to include* (core curriculum).
- History of forensic nursing and forensic nursing education.
- Forensic nursing education from the student perspective could be studied.
- Forensic nursing educational research extended to more countries for greater generalizability.
- Benefits of forensic nursing education for all stakeholders: patients, students, nurses, and society.

#### *Key Findings or Results (Outcomes) of the Study*

In exploring the knowledge of forensic nursing, the main outcomes of this study were constructed: A taxonomy of *knowledge concepts to include*; an *interprofessional educational practice model*; *social justice* as a suggested meta-theory for forensic nursing and forensic nursing education; *constructed definitions* of forensic nursing that included the *differentiation* of forensic nursing knowledge from nursing in general and from other

forensic disciplines, and the identification of the uniqueness of forensic nursing's dual knowledge. In point form the key findings or outcomes of this study were:

- ❖ *Taxonomy Knowledge Concepts to Include*
- ❖ *Interprofessional Educational Practice Model*
- ❖ *Meta Theory for Forensic Nursing/ Forensic Nursing Education*
- ❖ *Definition of Forensic Nursing Constructed*
  - *Differentiation of forensic nursing knowledge from nursing in general and from other forensic disciplines*
  - *Identification of the Uniqueness of Forensic Nursing's Dual Knowledge*

### *Forensic Nursing Knowledge*

As this specialty grows, forensic nursing knowledge is developing from the forensic nursing leaders in the field who are writing about their forensic clinical practice, conducting research on forensic victim and offender populations, and developing forensic educational courses. This study began to identify the differential knowledge for forensic nursing that was different from general nursing and different from other forensic disciplines (See Chapter Six, Knowledge Differentiated).

From the evidence gathered in this study, I determined that unique knowledge of forensic nursing was possibly the dual roles of care and concepts specific to each subspecialty, for example: care and custody, care and collection of evidence, care and court testimony, care and chain of custody, care and crisis intervention, and care and community protection (See Chapter Five, Knowledge Dual). I created constructed definitions of forensic nursing from the analysis of the knowledge themes (See Chapter Five, Knowledge Definition Constructed).

### *Factors Influencing Knowledge or Educational Development*

Social movements and public policies have influenced the development of forensic nursing, and the delivery of forensic nursing education. Radical changes have occurred in education and technology, at a time when global interest is high for the forensic sciences. Media exposure has brought a recent fascination and heightened curiosity about how infamous perpetrators think, and the social/legal issues of how to deal with offenders. There is also more concern about the care for their victims.

Events covered in the media have contributed to public awareness of how the applied sciences are used to help solve crimes, determine psychiatric assessment of those accused, and educate professionals in the identification and prevention of violence, trauma, and catastrophic injuries. In response to public policy, social trends, and media attention--forensic nursing has emerged as the nursing profession's most dynamic and fastest growing specialty. Partnerships and affiliations also influenced how courses were developed in that the forensic parameters or conceptualizations may have already been established.

*Societal need, reactive, and progressive nursing roles.* Historically, forensic nursing developed reactively in response to societal needs and demands for improved care for victims and for offenders. However, forensic nursing also developed proactively from the progressive efforts of forensic nursing pioneers who saw the need for improved care for their patients.

- ❖ Forensic nursing evolved from the need to increase the care to victims and perpetrators, some from societal need and some from our own need to improve the services.

A bandwagon effect occurred in the rise of popularity in the forensic professions, fueled by media attention to the word *forensics* (meaning forensic science or forensic medicine). Media exposure brought a fascination among the public with forensic science, and with all areas of working with victims, offenders, and forensic pathology.

When respondents were asked what social factors influenced the development of the specialty or educational courses, most of them mentioned the current media have created more awareness among the public rather than the many important historical social movements of the 1960s. The movements of human rights, gender and women rights, offender and victim rights, and inmate law suits were not mentioned, but respondents did mention more general awareness by the public.

*Significant individual.* There has been little doubt that social trends, media attention, public awareness, and advances in technology and science have all been influential variables in developing the conceptualization of forensic nursing. However, the enthusiasm, drive, and mission of a few individual forensic nurse educators were probably the most significant factors influencing forensic nursing educational development. Some of the data extracts supporting this are:

- At some point it became a mission. (Q13-P19)
- Well it's certainly been my mission in life, outside of raising my children. (Q13-P08)
- It became something I absolutely had to do. (Q13-P09)

### *Conclusion*

In this dissertation I explored forensic nursing knowledge as a specialty area and factors that influenced its educational development from the perceptions of nurse educators who have authored and taught forensic nursing courses. This mixed method

exploratory study used a constructivism approach. The research design of the study allowed for an interpretation of the data that followed Dewey's (1933; 1938) early principles of constructivism. Results of this study found that forensic nursing is a recognized specialty of nursing at the clinical-legal interface. Findings of this study may assist students, practitioners, administrators, and educators to further understand this emerging specialty.

Nurse educators have contributed to the construction of the forensic nursing specialty that is emerging worldwide. A finding from the integration of the analysis of the qualitative data and the descriptive statistics was the significance of the passion of educators who were driven and felt a mission to either pioneer a forensic nursing role, and/or develop some of the first forensic nursing educational courses. The significant finding, as previously noted was that many of the first forensic nursing program entered into curriculum at major colleges and universities were developed by nurses who were not doctoral prepared and were not on faculty at the time. This study revealed the important contribution of educators to the forensic nursing specialty and educational development. The significance of the educator's role in the identification of the unique forensic nursing knowledge and responsibility of course development had not been previously examined. Nor had the important role of educators in the evolution and advancement of a specialty and their contributions to a body of knowledge for this specialty.

It is hoped that the dissemination of the findings will provide more recognition and value to the important contributions made by clinicians as educators when new

specialties evolve. Forensic nurse educators have played an important role, not only in the development of educational courses and programs, but in the advancement of the specialty. It is also hoped the findings of this study will have relevancy to specialty education in general, and to interprofessional education in particular.

Definitions of forensic nursing were constructed from the responses and compared to earlier definitions developed by non researchable methods. The findings of this forensic nursing education study included the delineation of forensic nursing resulting in constructed definitions, the differentiation of forensic nursing knowledge that is different from general nursing and other forensic disciplines, and the demarcation of the forensic nursing as a distinct specialty with evidence of its assured and valuable place on the multidisciplinary health care team.

This study also explored social factors that influenced the educational development of the forensic nursing specialty, and addressed implications for forensic nursing practice, education, and research. A thematic analysis of the data and comparison to the literature from a constructivist approach provided an interpretation of factors that both facilitated and impeded forensic nursing specialty educational development in North America. Positive and negative accounts of social, media, technological, economic and political factors were provided that influenced the specialty and educational development. Forensic nursing education has made a difference in the improvement of care to patients and forensic nurse educators have played a key leadership role in the advancement of the specialty.

In the early years of forensic nursing education development, it became evident that more than one positive factor was needed to create and maintain new specialty programs that were not then recognized as future mainstay programs. Multiple social factors contributed to why forensic nursing courses were developed and why they were not developed sooner. As an intellectual process, constructivism was built on assumptions that knowledge is not static, that people and society undergo change, and that contexts function to facilitate or hinder, or otherwise influence human goals and psychosocial processes (Creswell, 1998). Therefore, from the constructivist worldview, multiple perspectives exist, and multiple and alternative factors are recognized to have influenced practice, education, and research in any discipline. From a constructivist interpretation to the findings of this study, all factors have relevance as all are needed for specialty programs to be developed and sustained.

### Summary of Chapter Six

In this final chapter, I discussed some of the issues facing forensic nursing education. An overview of the main outcomes or results of the study were reviewed: A taxonomy of *concepts to include*, an *interprofessional educational/practice model*, a *social justice as a meta theory of forensic nursing*, and *constructed definitions of forensic nursing* including the differential knowledge between forensic nursing and nursing in general and forensic nursing and other forensic disciplines, and the identification that unique to forensic nursing may be the dual roles of caring and concepts specific to each subspecialty. This study began an exploration of the knowledge of forensic nursing and



factors influencing the development of forensic nursing education. More research is needed on this specialty area to make any definite conclusions or determinations. I concluded the chapter by linking the relationship of the themes or theory to constructed knowledge and identifying the implications of forensic nursing education for theory, practice, education, and future research.

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## APPENDIX A – APPROVAL FORMS

## Appendix A1

## Email Invitation to Participate in Study

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Invitation to Participate in Forensic Nursing Education: An Exploratory Study

Dear

I am emailing you to invite you to participate in my International research study on Forensic Nursing Education: An Exploratory Study. You have been identified as an Educator who has written and taught a forensic nursing course.

Attached is a file with ALL the information about the study, Email Questionnaire, Phone Interview Questions and all Consent forms.

*Phase One*--Email Questionnaire

*Phase Two*--Semi-Structured Questions that will be asked in a Telephone Interview

Should you agree to the study – please do the following:

*Phase One*

- (1) Save the file attached to this email in your Word File Documents
- (2) Complete the Email Questionnaire on pages 5-8
- (3) Save and send the file back to me attached to an email
- (4) I will then email you to set up a convenient time for a phone interview
- (5) On page 13 are the semi-structured questions for the Telephone interview. You do not have to prepare for these questions in writing – they are sent now so that you will have time to think about your responses for the telephone interview.

*Phase Two*

- (6) Before the Telephone Interview – please sign the Audio-Taped Telephone Interview consent form (page 10) and FAX it back to me at (306) 966-1745 (or an electronic signature in email is also acceptable)
- (7) The study will also involve forensic nursing educational documents i.e. your Course Description of the course you wrote and the Course Index – which is the overview or list of the names of the units of study you have in your course. Can you also please send this document via email attachment.
- (8) After the audio-taped telephone interview, the interview will be transcribed and a copy of your transcription will be sent for your approval. Once you have read and made any changes and approve of your transcripts an indicative of what you wanted to say, please send transcript file back to me by email attachment with any changes. Then sign the Transcript Release Consent and fax it to me at 1-306-966-1745.

Thank-you

I look forward to hearing from you

Arlene Kent-Wilkinson

Appendix A2  
Letter of Invitation/  
Information about the Study

---



DATE: XXXXX, 2006

Dear [Participant #XX-PEUS- identified educator]

My name is Arlene Kent-Wilkinson and I am a doctoral student in the Department of Educational Administration in the College of Education at the University of Saskatchewan. I wish to invite you to participate in a study entitled '*Forensic Nursing Education: An Exploratory Study*.' Please read this form carefully, and feel free to ask any questions you might have.

The purpose of the study is to understand from the perspective of educators in university or college settings internationally, their perception of what the important concepts or topics were to include in their forensic nursing educational course(s), and what factors influenced the development of an educational program in this area.

Should you be willing to participate in this study, you will find attached to this email the consent form which you may print for your records. A written signature is waived due to the logistics of email limitations. A reply to this email and completion of the brief demographic survey also attached will signify your consent to continue in the study. Phase II of the study will involve a Telephone Interview that I will set up with you at a convenient time through our email correspondence. The questions you will be asked in the semi-structured phone interview are attached so that you will have in advance a guideline of the main questions you will be asked. You will not need to prepare your responses in writing.

Please note that this specific study is not in any way an evaluative study of past or present forensic nursing programs, it is rather a mainly qualitative study of only "what is", that is the perceptions of educators who have been responsible for forensic nursing course development as to what forensic nursing is and how the educational courses came about.

## Appendix A2 (cont.)

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Educators will be asked what their perception is of the unique knowledge of forensic nursing and how they decided what content or concepts to include in the course and to identify factors that influenced the development of this educational specialty. The data collection will involve an email questionnaire to gather descriptive demographic statistics and a document review which will involve your course descriptions and index of units of study from the forensic nursing course that you wrote and taught. Phase II of the study will be a semi-structured telephone interview for the qualitative data. With your consent, the phone interview will be audio recorded. You as a participant will be asked to sign a further consent for audio recording. Even if consent is given, participants at any time, for any reason during the interview may ask to have the audio recording device shut off.

The email questionnaire and the questions that will guide the semi-structured Telephone interview are attached. I will contact you by email to arrange an interview should you be interested in participating further. Within two to three weeks of our telephone interview, you will be asked to review the typed transcript of your responses. You may add, alter, or delete information from your transcript as you see fit. Then you will be asked to sign a transcript release form and fax it back to me as well

I look forward to your response to this request to participate. If you have any questions concerning the study, please feel free to contact me using the information below. You may also contact my supervisor, Dr. Sheila Carr-Stewart at 1-306-966-7611, and the, Office of Research Services, University of Saskatchewan at 1-306-966-2084 to ask any questions.

Sincerely,

Arlene Kent-Wilkinson RN, PhD(c)  
Department of Educational Administration  
University of Saskatchewan

Telephone: 1-306-966-7678 or ex 6897  
Facsimile: 1-306-966-1745  
e-mail: arlene.kent@usask.ca

Appendix A3  
Recruitment Information and Consent Form

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#XX-PEXX

The data from this study will be used in the completion of a doctoral dissertation. Data from this study may also be published and presented at conferences. To safeguard your confidentiality and anonymity, you will be given a pseudonym, and all identifying information such as your university, demographics about the forensic nursing course/program, participant background characteristics and responses that identify the educator or the program will be removed. Only aggregate results will be included in the final report.

Volunteer participants will be contacted from the population of approximately 20-30 known forensic nursing programs to date in Canada and the United States only. The criteria for your selection is that the educator must have written and taught at least one forensic nursing course.

Because the participants for this study have been selected from the small population sample of established forensic nursing educational programs internationally, anonymity cannot be guaranteed. As your responses may be identifiable to others on the basis of what you have said, I as the researcher will undertake to safeguard the confidentiality of the data by storing the contact data separate from the survey and telephone interview responses, and by using pseudonyms to identify the data. Also, you will be given the opportunity to review the transcript of your responses where you may add, alter or delete information from your transcript as appropriate.

The audio recordings of the telephone interview transcripts and all email communication, including the demographic survey results will be stored at the University of Saskatchewan, as will your contact information. This data will be stored in the office of my supervising professor, Dr. Sheila Carr-Stewart for five years, after which time they will be destroyed. You may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed.

## A3 (cont.)

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If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact me at the number and e-mail address provided above if you have questions at a later time. Also please feel free to contact my supervisor Dr. Sheila Carr-Stewart if you have any questions by telephone: 1-306-966-7611 or email: [sheila.carr-stewart@usask.ca](mailto:sheila.carr-stewart@usask.ca)

This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Science Research Ethics Board on [November 18, 2005]. Any questions regarding your rights as a participant may be addressed to that committee through the Office of Research Services, (ph: 1-306-966-2084) at the University of Saskatchewan. All participants may call collect.

When the dissertation is complete, a notice will be sent to each participant with regards to how to access the document from the University of Saskatchewan library. Each participant will be provided with an executive summary.

### Consent to Participate

I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above understanding that I may withdraw this consent at any time. A copy of this consent form may be printed for my records.

*Waived for email consent*

---

Signature of Participant

---

Date

---

Signature of the Researcher

The signature consent is waived due to the logistics and limitations of email. A reply to the researcher by email regarding your agreement to participate and the completion of the email demographic survey attached will indicate your willingness to continue in the study to phase II for the semi-structured telephone interview. The consent form for audio recording of a maximum 40 minute phone interview will be sent to the participant by email prior to the telephone interview. The participant will be asked to sign the consent and fax it back to the researcher prior to participating in the semi-structured phone interview.

## A4

## Consent for Audio Recorded Telephone Interview



Dear Participant #XX-PEXX

Consent for telephone interview will be verified at the beginning of interview by acknowledging receipt of the faxed signed consent. The consent process will be documented by logging the date, time, and name of the participant.

As you know from your earlier participation in a phase I of this study, my name is Arlene Kent-Wilkinson and I am a doctoral student in the Department of Educational Administration in the College of Education at the University of Saskatchewan.

Thank-you for your interest in participating in the semi-structured phone interview with me for this ground theory study entitled *Forensic Nursing Education: An Exploratory Study*. Please read this form carefully, and feel free to ask questions you might have. You may contact me at 1-306-966-7660 or by e-mail at [arlene.kent@usask.ca](mailto:arlene.kent@usask.ca). Also please feel free to contact my supervisor Dr. Sheila Carr-Stewart with any questions by telephone: 1-306-966-7611 or by email: [sheila.carr-stewart@usask.ca](mailto:sheila.carr-stewart@usask.ca)

As a reminder, the purpose of this study is to understand from the perspective of nurse educators and administrators in university or college settings internationally, an understanding of the essence of forensic nursing and how organizations foster new educational specialties - specifically forensic nursing education.

This telephone interview was arranged by email at a convenient time to verbally respond to the semi-structured interview questions you received by email. I have received by fax your written consent to participate in the semi-structured telephone interview. You may if you wish of course, print off a copy of the consent for your records.

With your consent the telephone interview will be audio recorded. At any time during the interview, you as the participant may for any reason ask to have the audio recording device shut off. The interview is semi-structured, but you may add topics you feel are significant as well. Within six weeks of our telephone interview, you will be asked to review the typed transcript of your responses. You may add, alter, or delete information from the transcript as you see fit. I may also need to contact you within six months for points of clarification that will assist me in the analysis.

## A4 (cont.)

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The data from this study will be used in the completion of a doctoral dissertation. The data from this study may also be published and presented at conferences. To safeguard confidentiality you will be given a pseudonym, and all identifying information such as your university, your forensic nursing program of study, and any responses that may identify you will be removed. Due to the small sample size of known forensic nursing programs globally, anonymity cannot be guaranteed, but every attempt will be made to only report aggregate data.

The audio recordings and transcripts of our discussion will be stored at the University of Saskatchewan, as will your contact information. These data will be stored in the office of my supervising professor, Dr. Sheila Carr-Stewart for five years.

You may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed.

If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact me at the number and e-mail address provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Science Research Ethics Board on (insert date), 2005. Any questions regarding your rights as a participant may be addressed to that committee through the Office of Research Services (ph: 1-306-966-2084) at the University of Saskatchewan. All participants may call collect.

When the dissertation is complete, a notice will be sent to each participant about how to access the document from the University of Saskatchewan library or other sources. An executive summary will also be sent to each participant.

Consent to Participate (Audio Recorded Phone Interview)

I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I hereby consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

Please fax signed consent to researcher Arlene Kent-Wilkinson at facsimile: 1-306-966-1745.

---

Signature of Participant

---

Date

---

Signature of the Researcher

## A5

## Transcript Release for Telephone Interview



#XX-PEXX

Direct quotations will not be reported in the final report of this study unless your written consent is given. Every attempt will be made to report aggregate data only in the final analysis. As direct quotations may compromise the anonymity of participants, it is appropriate to afford you as a participant the right to verify the accuracy of your responses and/or of the interpretation given to them. This transcript release form should only be signed after you have had the opportunity to read and revise your transcript in order to acknowledge that it accurately portrays what you said.

I, \_\_\_\_\_, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with the researcher of this study - Arlene Kent-Wilkinson. I hereby authorize the release of this transcript to Arlene Kent-Wilkinson to be used in the manner described in the consent form. I have received a copy of this Data/Transcript Release Form for my own records.

Please fax signed consent to researcher Arlene Kent-Wilkinson at facsimile 1-306-966-1745.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date



Appendix A6  
Application for Approval of Research Protocol  
Resubmitted to the Behavioural Research Ethics Board

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November 18, 2005

RESEARCHER: Arlene Kent-Wilkinson RN, BSN, MN (Doctoral Candidate)  
Department of Educational Administration

SUPERVISOR: Dr. Sheila Carr-Stewart  
Department of Educational Administration

DATA COLLECTION      START DATE:      November 18, 2005  
   COMPLETION DATE:      August 1, 2006

TITLE OF STUDY: Forensic Nursing: An Exploratory Study.

**ABSTRACT:**

This study will attempt to provide insight into the quintessence of forensic nursing by exploring how educators writing forensic nursing courses have determined what the unique knowledge is of this specialty, and how organizations and institutions of higher learning have fostered the educational development of forensic nursing. Recently the “forensic” focus has appeared as a popular new area of study within many of the behavioral science professions. Forensic nursing, one of the newest specialty areas of nursing is gaining momentum with educational programs appearing in curriculums of leading colleges and universities internationally. This study will seek to ascertain the essence of forensic nursing, as to its theoretical underpinnings. A thematic analysis will be conducted on the literature relevant to this study including the historical evolution of forensic nursing along the sequential pattern of specialty development. Ideological conflicts to date and factors that have influenced the development of this specialty will be investigated. Why some new focus areas evolve to specialty status with graduate and doctoral educational programs and others do not is of interest to Education Administration. When a new specialty first appears in any discipline or when two disciplines join as one, it is a challenge to integrate into an educational curriculum an epistemology that explains the theoretical foundations of the newly formed specialty. A grounded theory approach using a constructivism paradigm will draw out initial theory development. This predominately qualitative study will involve interviewing educators and administrators who have been responsible for the development of the 20-30 established forensic nursing programs globally. Data collection will include an email questionnaire and a phone interview. In the analysis, postmodernism will be used to illuminate and extend the constructivist grounded theory methodology.

FUNDING: This study is self-funded.

## Appendix A6 (cont.)

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**EXPERTISE:** The researcher is a nurse educator and has had the experience of writing and teaching forensic nursing courses for four different colleges/universities. The researcher has had over 30 years of direct clinical experience in many areas of forensic nursing practice.

**PARTICIPANTS:** The participants in this study are from the known population of approximately 30 forensic nursing earliest programs that have been identified as some of the earliest programs globally. The countries with known established programs are: Canada, United States, United Kingdom, Australia, and New Zealand. To recruit volunteer participants for this grounded theory study the researcher will draw from her database of forensic nursing programs that she has compiled over the years and kept current by professional connections and Internet searches. The criteria for the selection of participants is that the nurse educator must have written and taught at least one forensic educational course themselves and the administrator must have been the person responsible for supporting the addition of this program to the curriculum at their university/college. The purposefully identified participants will be invited by email to volunteer to take part in the study with the reassurance that they can opt out at anytime without penalty. Following informed consent and a descriptive email survey of demographic data, a maximum 40 minute semi-structured phone interview will follow. The study is limited to the new specialty of forensic nursing, cognizant that many other disciplines have also a forensic specialty focus. Nurse Educators and Administrators are the population of interest in this study as this homogeneous population has had a similar experience of the process, and may have the ability to contribute to an evolving theory.

The local Research Ethics Boards or equivalent bodies, whenever applicable, will be contacted when conducting research in multiple jurisdictions. Letters of support will be sought from the nursing faculties/colleges from which participants are drawn.

Participants will be initially contacted by email between November, 2005, and April of 2006. The data collection will involve an email survey to gather descriptive demographic statistics followed by a semi-structured phone interview for the qualitative data. Educators will be asked what their perceptions are of the unique knowledge of forensic nursing and how they decided what concepts to include in the course they wrote. Administrators will be questioned about factors that influenced the development of the forensic nursing courses. The analysis will consist of a constant comparison method of the interview responses of the educators with the administrators, and then contrasting both to a thematic analysis of the literature.

See Appendix A-1 Letter of Invitation, (includes General Information about the Study  
Appendix A-2 Recruitment Information and Consent Form

## Appendix A6 (cont.)

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Appendix A-3 Consent for Audio Recorded Phone Interview

Appendix A-4 Transcript Release of Phone Interview

See Appendix B-1 and B-2 for all Survey & Interview Questions detailed as follows:

Appendix B-1a Survey--Educators for Personal/Professional Information

Appendix B-1b Survey--Administrators for Course Information

Appendix B-2a Semi-Structured Phone Interview--Educators

Appendix B-2b Semi-Structured Phone Interview--Administrators

See Appendix C-1 Recruitment Data Base--List of Websites of all known Forensic Nursing Programs Internationally

Appendix C-2 Contact names of the Educators and Administrators for each program (compiled but not included here)

**CONSENT:** The written signature for consenting to Phase 1 of the study will be waived as the consent form will be sent by email along with the Letter of Information about the study. Agreement to participate in the study will be assumed by replying to the email and by the completion of the Demographic Survey that will be attached to the email. Phase 1 of the Study will be followed by an email communication exchange to set up a time for Phase II which will involve the Phone Interview. A consent form for an Audio Recorded Phone Interview (See Appendix A-3) will be sent to the participant by email, thus providing them with a copy of the information about the study and the consent for their own records. If participants agree to continue with Phase II, cognizant that they can withdraw at any time without penalty, they will then be asked to fax their signed consent back to the researcher. By doing so, participants attest that they have read and understood the description of the study provided, have been provided with an opportunity to ask questions, and have had their questions satisfactorily answered. Due to the small sample size of known programs globally, anonymity cannot be guaranteed, but every effort will be made to provide both anonymity and confidentiality by reporting only aggregate data. Measures used in the attempt to ensure confidentiality of the data will include using pseudonym names and keeping the consent forms separate from participant information. See Appendix A-3 for Consent form for Audio Recording of Phone Interview.

**METHODS:** Data will be collected by a demographic survey to collect descriptive statistics by email, a semi-structured individual interview by phone, and a thematic analysis of the literature. Approximately 20-30 interviews will be conducted that will include at least two in every country. The written transcripts generated from the audio recording of the semi-structured phone interviews will be emailed to each participant so that they will have the opportunity to read them, then to add, delete or change any of their own responses. The transcripts from the phone interviews will form the majority of the data for the study.

## Appendix A6 (cont.)

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The planned instruments will be a Participant Questionnaire to collect descriptive statistics by email (See Appendix B-1a & b), and a Questions Guide for a Semi-Structured Phone Interview developed from the Research Questions of this study (See Appendix B-2a & b). The Participant Questionnaire will consist of survey questions about demographic and professional experience and general questions about information pertaining to their forensic nursing courses. The Semi-Structured Interview will seek to discover from their personal experience the conceptualization and the essence of forensic nursing through the process of course development.

**STORAGE OF DATA:** All data collection and transcription will be done by the researcher. Transcripts will be stored on the file server of the University of Saskatchewan, on the hard drive of a personal computer in the home of the researcher, and on disk. A copy of transcripts and audio recordings will be stored at the University of Saskatchewan in the office of Dr. Sheila Carr-Stewart for five years following the completion of the study. After five years, the data will be destroyed.

**DISSEMINATION:** The data collected is intended for use in the doctoral dissertation of the researcher. A secondary intent is to use the data and findings of the research in conference presentations, journal articles, and other scholarly works. Participants will be made aware of the intents of the data collection prior to participating in the study and when the dissertation is complete, a notice will be sent to each participant as to how to access the document from the University of Saskatchewan library. Each participant will be provided with an executive summary.

**RISK OR DECEPTION:** Participants will not be deceived in the course of the study. Anonymity cannot be guaranteed due to the small sample size of the known established forensic programs globally, and also the fact that many of the participants know of each other and of their specific forensic program in each country. The researcher, however, will make every attempt to ensure confidentiality of the data, as it is collected.

**CONFIDENTIALITY:** Pseudonyms will be used in transcription and reporting of the data. The researcher will make every attempt to ensure confidentiality by only reporting aggregate data in the final report. No direct quotations will be used in the final analysis without the consent of the participant. In addition, participants will be given the opportunity to review their audio transcript and make any additions, deletions and alterations. However, because the data will be collected from a small population of known established forensic nursing programs and participants, the researcher's ability to ensure anonymity of data is limited. See the sections on confidentiality contained in Appendix A and B

## Appendix A6 (cont.)

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**DATA/TRANSCRIPT RELEASE:** Participants will receive a copy of their phone interview transcript by email. Participants will be given the opportunity to add, delete, or alter their transcript prior to faxing back to the researcher their signed consent for release of the transcript. Participants will have the right to withdraw at any time for any reason any or all of their responses without penalty in any way. The data will be destroyed after five years. To ensure confidentiality, transcript release forms and transcripts will be stored separately.

See Appendix A-4 for Transcript Release Form of Phone Interview

**DEBRIEFING AND FEEDBACK:** At the conclusion of each phase of the study, through to the final transcripts for review, the participants will be reminded (through email and phone correspondence) of the next steps that will be taken in the study, and will be invited to ask questions of the researcher. Questions or comments will be invited at any time and participants will have the necessary information to contact the researcher at 1-306-966-6897 or 1-966-7678, the Department of Educational Administration at 1-306-966-7611, and the Office of Research Services at the University of Saskatchewan at 1-306-966-2084.

*REQUIRED SIGNATURES*

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Arlene Kent-Wilkinson, Doctoral Student

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Dr. Sheila Carr-Stewart, Supervisor

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Dr. Sheila Carr-Stewart, Department Head

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Dr. Cecilia Reynolds, Dean, College of Education

*CONTACT INFORMATION*

Arlene Kent-Wilkinson  
c/o Department of Educational Administration  
University of Saskatchewan  
Room 3054 - 28 Campus Drive  
Saskatoon, SK., S7N 0X1

Home telephone: 1-306-244-4117  
Office telephone: 1-306-966-7678  
Office telephone: 1-306-966-6897  
Facsimile: 1-306-966-1745  
e-mail: [arlene.kent@usask.ca](mailto:arlene.kent@usask.ca)



# Department of Educational Administration

## Report on Comprehensive Exam of Ph.D. Student

This is to certify that

Arlene Kent-Wilkinson

200677

a doctoral student in the Department of Educational Administration, College of Graduate Studies, University of Saskatchewan, has passed the candidacy exam. We now recommend to the College of Graduate Studies that the above named student be granted the status of fully-qualified candidate for the degree of Ph.D. in Educational Administration on December 10, 2004

Chair

P. Renihan, Educational Administration

Advisor

S. Carr-Stewart, Educational Administration

Committee Members

R. Wimmer, Educational Administration

L. Sackney, Educational Administration

Cognate Member

S. McLean, Extension Division

Patrick J. Renihan  
Department Head

December 10, 2004



# Department of Educational Administration

## ACCEPTANCE OF DISSERTATION PROPOSAL

Arlene FName	Kent-Wilkinson LName	200677 Student#	satisfactorily completed Preliminary Oral Examination of thesis topic titled:
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The Essence of Forensic Nursing: How Organizations Internationally Foster New Educational Specialities

on November 21, 2005

Chair

P. Renihan, Educational Administration

Advisor

S. Carr-Stewart, Educational Administration

Committee Members

R. Wimmer, Educational Administration

L. Sackney, Educational Administration

Cognate Member

J.S. Wormith, Department of Psychology

Submitted to College of Graduate Studies on: November 21, 2005

\_\_\_\_\_  
Sheila Carr-Stewart  
Department Head

## Appendix B1

PHASE I (a) Email Survey -Educator

---

#XX-PEXX

## PHASE I(a) - Email Survey - Descriptive Statistics - Educator

Please complete the following data about yourself by typing an X anywhere between the brackets or write in the blank.

## 1. Location and Gender

Please indicate:

County: .....

State/Province: .....

Gender:

Please indicate:

Female: .....

Male: .....

## 2. Professional education: Select all that apply:

☐ RN☐ BN or BSN in nursing (RN)☐ Non-Nursing degree☐ MN or MSN in Nursing☐ Doctorate in progress (Ph.D or DNSc student)☐ Doctoral degree other than nursing .....☐ Doctoral degree in nursing .....

## 3. Please state the number of years of direct clinical nursing experience you have in

other nursing areas(s): \_\_\_\_\_years

Please state the number of years of direct clinical nursing experience you have in

forensic nursing areas(s): \_\_\_\_\_years

## 4. Focus area(s) of nursing is: .....

Focus area(s) of forensic nursing is: .....



## Appendix B1 (cont.)

PHASE I (a) Email Survey -Educator

---

5. Have you taken any forensic courses yourself?

☐ No

☐ Yes please describe .....

Have you taken any forensic nursing courses yourself

☐ No

☐ Yes please describe .....

.....

6. How many forensic nursing courses have you developed?

☐ 1

☐ 2

☐ 3 or

☐ specify

Please list the titles of the Courses:

.....

.....

.....

.....

7. Your current position and responsibilities? Please describe .....

Type of position

☐ full time

☐ part time

☐ Sessional/contract

8. How many years have you taught nursing? \_\_\_\_ years

How many years have you taught forensic nursing? \_\_\_\_\_ years

## Appendix B1 (cont.)

PHASE I(b) Email Survey –Course

---

#XX-PEXX

## Email Survey - Descriptive Statistics - Course

These questions pertain to your institution and to your forensic nursing course (s)  
Check all that apply

9. Type of Institution/Organization?

- ☐ College
- ☐ University
- ☐ other

10. Was a needs assessment done prior to course development?

- ☐ yes
- ☐ no

11. Level of course?

- ☐ certificate
- ☐ undergraduate
- ☐ graduate
- ☐ doctoral
- ☐ other

12. Is there a pre-requisite?

- ☐ No
- ☐ Yes

If so, please specify .....

13. To which students are you teaching forensic nursing?

- ☐ nursing
- ☐ nursing & other disciplines

14. What is the mode of delivery for dissemination of course information?

- ☐ classroom
- ☐ distance (paper based)
- ☐ online (web based)
- ☐ hybrid (classroom & web enhanced)

## Appendix B1 (cont.)

PHASE I(b) Email Survey –Course

---

15. Is there a clinical component to the forensic nursing program?

☐ no

☐ yes

16. What year was your Forensic Nursing Course/Program first offered at your university/college?

.....

17. What is/was the number, name and title of the forensic course at your institution?

Examples: FORE 4401: Health care in forensic populations

NURS 475.3: Forensic nursing in multiple environments

Insert here .....

18. How many electives options are available in the student's program of study?

☐ 1 elective

☐ 2 electives

☐ unsure

Explain: .....

Is your Forensic nursing course –

☐ required

☐ elective

19. How many times a year is your course offered?

☐ 1 semester

☐ 2 semesters

☐ 3 semesters

☐ other

Explain.....

20. How many students a year register for your forensic nursing course(s)

☐ 1-5 students

☐ 6-10 students

☐ 11-20 students

☐ 21-30 students

☐ 31-50 students

☐ 51 and over students

21. Other Comments

## Appendix B2

PHASE II - Semi-Structured Phone Interview

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#XX-PEXX

(Qualitative) Time estimates – 40 minutes maximum

1. What is forensic nursing? (meaning, essence, core, definition)
2. How did you conceptualize the forensic nursing educational content in your course/program of delivery? (i.e. forensic sciences, forensic behavioral sciences, nursing, justice, criminology, etc)
3. What philosophical base does your course adhere to?
4. What philosophical base your nursing program adhere to?
5. What is the unique knowledge of forensic nursing or core concepts to include that are different from nursing in general, and different from other disciplines on the multidisciplinary team?
6. The nurse educators will also be asked about the process of their course development: as to where they gained their knowledge of this specialty area. (i. e. personal clinical experience, publications, previous forensic nursing courses, and forensic nursing research to date).
7. What were the titles of your units of study (course index, modules). Please send/ include the course index for the data collection/thematic analysis of this study.
8. What was the best or most satisfying thing about developing and teaching this forensic nursing course?
9. How have organizations fostered new specialty educational development?
10. How have institutions of higher learning supported forensic nursing as a new evolving specialty in the development of educational programs?
11. What social, media, economic, and technologic factors have influenced (positively or negatively) this specialty educational development?
12. Why have formalized forensic nursing courses not been developed earlier for college and university delivery?
13. How factors influence whether a course or program is sustained?

## APPENDIX C1

Forensic Nursing Educational Programs Globally-Websites

---

Attached is a list of all known forensic nursing educational programs to date.

## Forensic Nursing Educational Programs – Globally

**Africa****South Africa, Africa**

University of the Free State, South Africa.

<http://www.uovs.ac.za>

Faculty of Health Sciences School of Nursing

Qualification in Forensic Nursing

<http://www.uovs.ac.za/fac/health/registerednursing/ForensicNursing.doc>

**Australia****North Queensland, AU**

Townsville and Cairns,

James Cook University in Australia.

<http://www.jcu.edu.au/theuni/>

MSc in Forensic Mental Health

NS5360:03 Issues in Forensic Mental Health 1

NS5362:03 Issues in Forensic Mental Health 2

<http://www.jcu.edu.au/courses/handbooks/2004/subjects/ns5360.html>

**South Australia**

The Flinders University of South Australia

Adelaide, SA

<http://www.flinders.edu.au/>

Graduate Certificate in Health (Clinical Forensic Nursing)

[http://adminwww.flinders.edu.au/courses/postgrad/clin\\_forensic.htm](http://adminwww.flinders.edu.au/courses/postgrad/clin_forensic.htm)

Graduate Certificate in Health (Correctional Nursing)

[http://adminwww.flinders.edu.au/courses/postgrad/correct\\_nurse.htm](http://adminwww.flinders.edu.au/courses/postgrad/correct_nurse.htm)

**Western Australia**

Edith Cowan University (Flexible delivery)

School of Nursing and Public Health

Perth, WA

<http://www.cowan.edu.au/>

Postgraduate Certificate in Forensic Mental Health Nursing

[http://www.ecu.edu.au/acserv/hb2002/pg/chs/school\\_of\\_nursing\\_and\\_public\\_health/post\\_graduate\\_certificate\\_in/forensic\\_mental\\_health\\_nursing.html](http://www.ecu.edu.au/acserv/hb2002/pg/chs/school_of_nursing_and_public_health/post_graduate_certificate_in/forensic_mental_health_nursing.html)

APPENDIX C1 (cont.)

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**Western Australia**

University of Notre Dame

Fremantle, WA

<http://web.nd.edu.au>

Postgraduate unit in clinical forensic nursing

[http://web.nd.edu.au/news/media/2003/forensic\\_nursing.shtml](http://web.nd.edu.au/news/media/2003/forensic_nursing.shtml)

**Canada****Alberta, Canada**

Mount Royal College,

Calgary, AB

<http://www.mtroyal.ca>

Forensic Studies

<http://www.mtroyal.ca/forensic>

**Alberta, Canada**

University of Calgary,

Calgary, AB

<http://www.ucalgary.ca>

NURS 503.08 Introduction to health care and forensic populations

[http://www.forensiceducation.com/forensic\\_edu/503.08description.htm](http://www.forensiceducation.com/forensic_edu/503.08description.htm)

**British Columbia, Canada**

BCIT - British Columbia Institute of Technology

<http://nobel.scas.bcit.bc.ca>

Forensic Science Technology: Advanced Specialty Certificate Program

<http://nobel.scas.bcit.ca/forensic/courses.htm#advancedSpecialty>

**British Columbia, Canada**

Douglas College

Vancouver, BC

<http://www.douglas.bc.ca/>

2004 Forensic Nursing Certificate

"Intro" to nursing in the justice system (1-604-527-5420).

<http://www.douglas.bc.ca/calhtm/courses/cnurs.htm>

APPENDIX C1 (cont.)

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**Ontario, Canada**

Seneca College of Applied Arts & Technology

Nursing Program, School of Health Sciences

Forensic Health Studies Certificate Program

<http://www.senecac.on.ca/healthsc>

<http://www.senecac.on.ca/healthsc/forensichealthstudies/index.htm>

**Saskatchewan, Canada**

University of Saskatchewan, College of Nursing

Saskatoon, SK

<http://www.usask.ca>

NURS 486.3 - Forensic Nursing in secure environments

<http://www.usask.ca/nursing/postreg/index.htm>

MN with forensic focus <http://www.usask.ca/nursing/masters/index.html>

**Ireland****Ireland**

Royal College of Surgeons,

St Stephens Green

Dublin, Ireland

Psychiatric Nursing in Forensic and Secured Environments

(1 year) Certificate course

<http://www.rcsi.ie>

**New Zealand****Wellington, NZ**

Whitireia Community Polytechnic,

Porirua, NZ

<http://www.whitireia.ac.nz>

Postgraduate Certificate in Forensic Psychiatric Care

[http://www.whitireia.ac.nz/programme.php?key=67&career\\_id=Forensic%20Psychiatric%20Carer](http://www.whitireia.ac.nz/programme.php?key=67&career_id=Forensic%20Psychiatric%20Carer)

## APPENDIX C1 (cont.)

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**United Kingdom****England, UK**

University of Liverpool  
Liverpool, England, UK  
<http://www.liv.ac.uk>  
Post-graduate Diploma in Forensic Behavioral Science  
leading to 2 yr Masters degree MSc  
in forensic behavioral science (thesis)

**England, UK**

University of Teesside  
Middlesbrough, Cleveland, UK  
<http://mental-health.tees.ac.uk/>  
Forensic Health and Social Care  
Forensic Multidisciplinary Practice  
24 credits  
Mental Disorder and crime  
<http://www.tees.ac.uk/schools/soh/subjects/modspec.cfm?ID=867&SubAreaID=14>

**Scotland, UK**

University of Dundee,  
Dundee, Scotland  
<http://www.dundee.ac.uk>  
Forensic Medicine, School of Nursing  
BN Forensic Nursing Module  
<http://www.dundee.ac.uk/forensicmedicine/nurse/nurseindex.htm>

**England, UK**

King's College London, University of London,  
Institute of Psychiatry at the Maudsley  
<http://forensic.iop.kcl.ac.uk/msc/downloads/Forensic-Mental-Health-Science.pdf>  
MSc in Forensic Mental Health Science.  
<http://www.iop.kcl.ac.uk/iopweb/departments/home/default.aspx?locator=431>



## APPENDIX C1 (cont.)

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**United States****California, USA**

American Forensic Nurses

Palm Springs, CA,

<http://www.amrn.com>

Forensictrack

<http://www.forensictrak.com>**California, USA**

University of California

Riverside Extension

Riverside, CA

Forensic nursing certificate program (online)

<http://www.ucrextension.net/certificates/forensic-nurse.html><http://www.extension.ucr.edu/certificates/forensic-nurse.html>**Colorado, USA**

Beth-El College of Nursing

University of Colorado

Colorado Springs, CO,

<http://web.uccs.edu/bethel/>

Graduate Certificate in Forensic Nursing

[http://www.uccs.edu/~bethel/certificate\\_programs.htm](http://www.uccs.edu/~bethel/certificate_programs.htm)**Connecticut, USA**

Quinnipiac University

Hamden, CT,

<http://www.quinnipiac.edu>

Master of Science in Forensic Nursing

<http://www.quinnipiac.edu/x1338.xml>**Idaho, USA**

Canyon College

Caldwell, ID

Online Forensic Nursing Certificate Program

<http://www.canyoncollege.edu/forensicnur.htm>

APPENDIX C1 (cont.)

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**Idaho, USA (cont.)**

Canyon College

Caldwell, Idaho

<http://www.canyoncollege.edu/cc/nur625/syllabus/nur625.htm>

**Louisiana, USA**

Louisiana State University Health Sciences Center (LSUHSC)

New Orleans, LA

<http://www.lsuhs.edu>

Introduction to Forensic Nursing

<http://www.nursingsport.lsuhs.edu/>

<http://nursing.lsuhs.edu/ContinuingEducation/Programs/Spring/Forensics2.cfm>

**Maryland, USA**

Johns Hopkins University School of Nursing

Baltimore, MD

<http://www.jhu.edu>

Masters of Science in Nursing; clinical nurse specialist, forensic nursing

[http://www.son.jhmi.edu/academics/academic\\_programs/masters/clinical\\_forensic.aspx](http://www.son.jhmi.edu/academics/academic_programs/masters/clinical_forensic.aspx)

**Massachusetts, USA**

Fitchburg State College

<http://www.fsc.edu>

Fitchburg, MA

Forensic Certificate Program

<http://www.fsc.edu/catalog/Grad/forensicnursing.html>

MS—Nursing (Specialty: Forensic Nursing)

<http://www.fsc.edu/catalog/Grad/nursing.html>

**New Jersey, USA**

Monmouth University

West Long Branch, NJ

<http://www.monmouth.edu>

Forensic Nursing Certificate

<http://www.monmouth.edu/academics/schools/graduate/programs/fngc.asp>

Masters of Science in Forensic Nursing

<http://www.monmouth.edu/academics/registrar/msnforensic02.asp>

APPENDIX C1 (cont.)

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**New Jersey, USA (cont.)**

Seton Hall University, College of Nursing  
South Orange, NJ  
<http://www.shu.edu>  
Graduate Nursing  
Dimensions of Violence: Individual course  
Assessment of sexual assault survivors

**New York, USA**

Kaplan College  
New York, NY  
<http://www.kaplancollege.edu>  
Forensic Nursing Certificate Program online  
<http://www.elearners.com/program/4038.htm>

**Ohio, USA**

University of Cleveland State  
Cleveland, OH  
<http://www.csuohio.edu/nursing>  
Masters of Science in Nursing: Population Forensics  
<http://www.csuohio.edu/nursing/Forensic%20graduate%20bulletin.pdf>

**Ohio, USA**

University of Cincinnati  
<http://nursing.uc.edu>  
College of Nursing  
Cincinnati, OH  
Advanced Concepts in Forensic Nursing  
<http://nursing.uc.edu/ProfessionDevelop/ForensicNursing.html>

**Ohio, USA**

Xavier University  
Cincinnati, OH  
<http://www.xu.edu>  
Master of Science in Nursing with Forensics Concentration  
<http://www.xu.edu/MSN/forensics/forensics.html>

APPENDIX C1 (cont.)

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**Oklahoma, USA**

University of Central Oklahoma

Edmond, OK

<http://www.ucok.edu>

Department of Nursing

Master of Science in Forensic Sciences (Forensic Nursing)

<http://204.154.117.68/nursing/msin.htm>   <http://nurse.ucok.edu:8080/MSForensic.jsp>**Pennsylvania, USA**

Duquesne University

Pittsburgh, PA

<http://www.nursing.duq.edu>

MSN Forensic Nursing (MSN, Post MSN, PhD) online

<http://www.nursing.duq.edu/gradMsnForen.html><http://www.forensics.duq.edu/academicprograms%20folder/nursingmasters.html>**Pennsylvania, USA**

La Roche College

Pittsburgh, PA

<http://www.laroche.edu/home.asp>

Forensic Nursing Certificate Program

<http://www.laroche.edu/schools/professions/DisciplineDetail.asp?DisciplineID=96>**Pennsylvania, USA**

University of Scranton

Scranton, PA

<http://matrix.scranton.edu>

Nursing 444 Forensic Health Care of Victims

**Pennsylvania, USA**

University of Pennsylvania, School of Nursing

Philadelphia, PA

<http://www.nursing.upenn.edu/>

MSN Minor in forensic nursing

Forensic science, Forensic mental health nursing, Victimology

APPENDIX C1 (cont.)

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**Tennessee, USA**

Vanderbilt University, School of Nursing

Nashville, TN

<http://www.vanderbilt.edu/>

Masters of Science in Nursing Program. Forensic Nursing

<http://www.mc.vanderbilt.edu/nursing/msn/forensic.html>

**Tennessee, USA**

University of Tennessee

Health Science Centre

<http://www.utmem.edu/>

Memphis, TN

MSD PhD Forensic Focus DNSc

the Integrated Model of Forensic Nursing

<http://www.utmem.edu/nursing/future%20students/DNP/forensic%20nursing/index.php>

**Washington State**

Gonzaga University

Spokane, WA

<http://www.gonzaga.edu>

Masters of Science in Nursing, with option of forensic/corrections

**Washington State**

University of Washington

Seattle, WA

Advanced Practice Forensic Nurse Specialist

APFNS program leading to MN

38-credit course of study leading to a Master of Nursing (MN) degree

<http://www.son.washington.edu/eo/apfns/>

**West Virginia**

Carilion Health System

Forensic Nurse Examiner Program

<http://www.carilion.com/sane>

## Appendix C2 Forensic Nursing Educational Programs\_Course Information

## Canada - Forensic Nursing Programs

Institution	Year Commenced	Mode of Delivery	Level of Preparation	Total Credit Hours	Clinical Comp hrs	Focus/Roles	No./Name of Course
University of Calgary, Calgary, AB, Canada	1995-2002 Spring	Classroom 1995-2002	In BN Program	48 hrs (3 credit)	0	All	NURS 503.08 Introduction to nursing and health care in forensic populations
	2002-current Spring	Online WebCT 2002-2005 current	Post Diploma (Post RN) BN Program	48 hrs (3 credit)	0	All	NURS 503.08 Focus on Forensic: Introduction to nursing and health care in forensic populations
University of Saskatchewan, Saskatoon, SK, Canada	2003-current Post BSN Program	Distance Delivery/ Online Blackboard 2005	Post Diploma (Post RN) BN Program	48 hrs (3 credit)	0	Forensic Psych/ Corrections	NURS 486.3 - Forensic Nursing in secure environments
	2008? Graduate	Online Delivery Blackboard	Graduate elective	(3 credit)	0	Forensic Health Issues	NURS 815.3_Advanced Forensic Mental Health
BCIT - British Columbia Institute of Technology	2005 Jan						Advanced Specialty Certificate Program <a href="http://nobel.scas.bcit.bc.ca/forensic/index.htm">http://nobel.scas.bcit.bc.ca/forensic/index.htm</a>
Seneca College, Ontario	2006	Distance Delivery/ Online WebCT 2006					Forensic Health Studies Certificate Course <a href="http://www.senecac.on.ca/healthsc">http://www.senecac.on.ca/healthsc</a>

## Canada (Cont) - Forensic Nursing Programs

University	Year commenced	Mode of Delivery	Level of Preparation	Total Credit Hours	Clinical Component (hrs)	Roles Specified	Comments
Mount Royal College, Calgary, AB, Canada	1997-Winter /Fall	Online Blackboard	Post Graduate Forensic Studies Program	48 hrs (3 credit)	0	All	FORE 4401 Forensic History, Risk Populations and Issues
	1999-current Fall-Winter	Online Blackboard	Post Graduate Forensic Studies Program	48 hrs (3 credit)	0	Forensic Psych/ Corrections	FORE 4403 Forensic Psychiatric and Correctional Populations
	2001	Online Blackboard	Post Graduate Forensic Studies Program	48 hrs (3 credit)	0		FORE 4405 Victims of Violence
	2000	Online Blackboard	Post Graduate Forensic Studies Program	48 hrs (3 credit)	0		FORE 4407 Forensic Science
	2000	Online Blackboard	Post Graduate Forensic Studies Program	48 hrs (3 credit)	0		FORE 4409 Expert Witness Testimony
	2000	Online Blackboard	Post Graduate Forensic Studies Program	48 hrs (3 credits)	0		FORE 4411 Crime Scene Investigation and Evidence

	2003 Fall	Online Blackboard	Post Graduate Forensic Studies Program	48 hrs (3 credit)	0		FORE 4413 Sexual Assault Examination and Intervention Theory
	2003 Fall		Post Graduate Forensic Studies Program	16 hrs (1 credit)	Yes		FORE 4415 Sexual Assault Examination and Intervention Practicum

## MRC Forensic Studies Program

Course Number	Course Name	Offering
FORE 4401-080	Forensic History, Risk Populations and Issues	Web delivery
FORE 4403-080	Forensic Psychiatric and Correctional Populations	Web delivery
FORE 4405-081	Victims of Violence	Web delivery
FORE 4407-080	Forensic Science	Web delivery
FORE 4409-080	Expert Witness Testimony	Web delivery
FORE 4411-080	Crime Scene Investigation and Evidence	Web delivery
FORE 4413-080	Sexual Assault Examination and Intervention Theory	Web delivery
FORE 4415-080	Sexual Assault Examination and Intervention Practicum	Web delivery



## AUSTRALIA - Forensic Nursing Programs

University	Year commenced	Mode of Delivery	Level of Preparation	Total Credit Hours	Clinical Component (hrs)	Roles Specified	Comments
Flinders University, Calgary, AB, Canada	2000-current Post Graduate Program	Online WebCT	Graduate Certificate in Health/ Graduate Diploma in Nursing (Correctional Nursing)	48 hrs (3 credit)	0	Forensic Psych/ Correctional Nursing	NURS 8905 – Prisons: Systems, Populations and Health Care NURS 8906 - Practice Issues in Correctional Nursing NURS 8907 - Correctional Nursing and Specific Populations
	2000-current Post Graduate	Online WebCT	Graduate Certificate in Health/ Graduate Diploma in Nursing (Clinical Nursing)	48 hrs (3 credit)	0	Forensic Clinical Nursing	3 clinical Courses
Edith Cowan University Perth, Western Australia		Flexible	Postgraduate Certificate in Forensic Mental Health Nursing			Forensic Mental Health Nursing	NFS 5101 Fundamentals of Forensic Nursing and management NFS 5102 Assessment of the Mentally Disordered Offender NSP5242 Advanced Nursing Practice (an in-depth focus on an aspect of forensic mental health care chosen by the student and assigned Tutor) NFS 5103 Forensic Nursing Intervention Skills <u>or</u> CMH5101 Harm Minimization (focus on minimizing self-harm)
James Cook University in Australia.	2003		MSc in Forensic Mental Health Graduate  Certificate of Forensic Mental Health	80 contact hours.	80 contact hours.		NS5360:03 Issues in Forensic Mental Health 1 NS5362:03 Issues in Forensic Mental Health 2 .

## New Zealand - Forensic Nursing Programs (cont).

University	Year commenced	Mode of Delivery	Level of Preparation	Total Credit Hours	Clinical Component (hrs)	Roles Specified	Comments
Whitireia Community Polytechnic, Porirua, New Zealand	1992	Online since 1998	Postgraduate Certificate in Forensic Psychiatric Care	40 weeks campus 36 weeks online	Each module contains theory and practicum /fieldwork experience	Forensic Psychiatric health care	Four ten-week modules

## United Kingdom - Forensic Nursing Programs (cont).

University	Year commenced	Mode of Delivery	Level of Preparation	Total Credit Hours	Clinical Component (hrs)	Roles Specified	Comments

### USA - Forensic Nursing Programs

University	Year commenced	Mode of Delivery	Level of Preparation	Total Credit Hours	Clinical Component (hrs)	Roles Specified	Comments
<b>California</b> U of California Palm Springs	Summer 2003		Certificate program in forensic nursing				American Forensic Nurses' ForensicTrak program
<b>Colorado</b> U of Colorado Beth el	1992		Masters	46-47	480	SANE or Investigator	CNS designation
<b>Connecticut</b> Quinnipiac Hamden, CT	1999 pilot 2000	onsite	Masters	40	500	Variety	CNS will be MSN SANE/SART offered annually May 2000
		Onsite		2 hrs			NU 585 Legal and Ethical Issues in Forensic Nursing 1
		Onsite		1 hr.			NU 586 Holistic Care in Forensic Nursing 1
		Onsite		2 hrs			NU 587 Holistic Care in Forensic Nursing Practicum 1
		Onsite		2 hrs			NU 608 Legal and Ethical Issues in Forensic Nursing II
		onsite		1 hr			NU 610 Forensic Photography
<b>Louisiana</b> LSUHSC New Orleans	1991	Classroom	BSN	30	Optional variable	Variety	Introduction to Forensic Nursing
<b>Maryland</b> Johns Hopkins University	2001		Masters	39		Variety	SANE training required

## USA - Forensic Nursing Programs (Cont)

University	Year commenced	Mode of Delivery	Level of Preparation	Total Credit Hours	Clinical Component (hrs)	Roles Specified	Comments
<b>Massachusetts</b> Fitchburg University Fitchburg Mass	1996	Classroom	Masters Post Masters	36 21	420	None	Weekends, evenings, and part times study
<b>New Jersey</b> Monmouth University West Long Branch	2001	Online certificate Onsite masters focus	Masters Post Bac Certificate	41 23	SANE (100 hrs) Forensic specialization	Variety Variety	On line certificate Certificate course can be applied to MSN degree
<b>New Jersey</b> Seton Hall University	2000	Online/ Onsite	Graduate	3cr 46	4 hrs	Multidisciplinary	
<b>New York</b>  Kaplan College New York, N.Y	2001?	Online	Forensic Nursing Programs				
<b>New York</b> Rochester			Not specified	3	No information	Variety	Offered to RN's as overview course
<b>Ohio</b> Xavier University Cincinnati, Ohio	2001		Masters	36		Variety	<a href="http://www.xu.edu/">http://www.xu.edu/</a>
<b>Oklahoma</b> U Central OK			Masters	34	No info	Variety	Successful completion of two examinations required

## USA - Forensic Nursing Programs (cont).

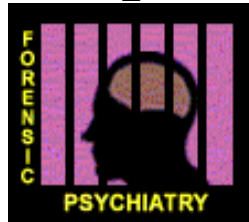
University	Year commenced	Mode of Delivery	Level of Preparation	Total Credit Hours	Clinical Component (hrs)	Roles Specified	Comments
<b>Pennsylvania</b> Duquesne Pittsburg, PA.	2002 summer	Online Classroom on campus	Masters Post Masters	36 19	No info	Variety of roles	All nursing courses online 24 credits 12 credit Wecht Institute course (onsite or online)
<b>Pennsylvania</b> U of Penn Philadelphia	Early 1990	onsite	Masters	9		Forensic Psych	Courses offered as "minor" for Master's preparation
<b>Pennsylvania</b> University of Scranton,				3 credits			Nursing 444-Forensic Health Care of Victims Required: Psych 110 Fundamentals of Psychology Recommend: CJ 110 Intro to CJ
<b>Tennessee</b> University of Tennessee	2001						University of Tennessee Health Science Centre
<b>Tennessee</b> Vanderbilt Nashville,	2004 Masters of Science in Nursing – Forensic Nursing Focus		Masters	39	No information	Correctional Nurse	Grads eligible for ANCC Adult NP certification
<b>Washington</b> Gonzaga University Spokane,			Masters Post Masters	43 24	450 450	Variety	Not listed on their website
<b>Washington</b> University of Washington Seattle, Washington,			Advanced Practice Forensic Nurse Specialist	38-credit course			1 year APFNS program leading to MN

## APPENDIX C3

## Forensic Concepts Taxonomy 2002

**Focus on Forensic \_ Course Content Index- 5 Topics (cont.)**

(RN)

(Forensic  
Behavioral Sc)(Forensic  
Sciences)

(Prison)



(ER)

FORENSIC  
NURSINGFORENSIC  
PSYCHIATRICFORENSIC  
MEDICINEFORENSIC  
CORRECTIONALFORENSIC  
CLINICAL (ER)

History & Theory  
Specialties & Roles  
Systems & Services  
Practice & Prevention  
Populations at Risk  
Concepts & Issues  
Future/ Education/  
Research/ Career  
Opportunities

History & Theory  
Specialties & Roles  
Systems & Services  
Practice & Prevention  
Populations at Risk  
Concepts & Issues  
Future/ Education/  
Research/ Career  
Opportunities

History & Theory  
Specialties & Roles  
Systems & Services  
Practice & Prevention  
Populations at Risk  
Concepts & Issues  
Future/ Education/  
Research/ Career  
Opportunities

History & Theory  
Specialties & Roles  
Systems & Services  
Practice & Prevention  
Populations at Risk  
Concepts & Issues  
Future/ Education/  
Research/ Career  
Opportunities

History & Theory  
Specialties & Roles  
Systems & Services  
Practice & Prevention  
Populations at Risk  
Concepts & Issues  
Future/ Education/  
Research/ Career  
Opportunities

Kent-Wilkinson 2002

**Focus on Forensic Course Content Index- 5 Topics (cont.)**

Forensic Nursing History & Theory	Forensic Psychiatric History & Theory	Forensic Medicine History & Theory	Forensic Corrections History & Theory	Forensic Clinical ER History & Theory
Historical & Legal Timelines Theories & Philosophies (Caring)	Historical & Legal Timelines Theories & Philosophies (Caring & Custody)	Historical & Legal Timelines Theories & Philosophies (Caring & Evidence Collection)	Historical & Legal Timelines Theories & Philosophies (Caring & Custody)	Historical & Legal Timelines Theories & Philosophies (Caring & Evidence Collection)
<b>Forensic Nursing Specialties &amp; Roles</b>	<b>Forensic Psychiatric Specialties &amp; Roles</b>	<b>Forensic Medicine Specialties &amp; Roles</b>	<b>Forensic Correctional Specialties &amp; Roles</b>	<b>Forensic Clinical ER Specialties &amp; Roles</b>
Forensic Nurse Clinical Forensic ER Nurse Correctional Nurse	Forensic Psychiatrist Forensic Psychologist  Forensic OT/RT	Medical Examiner Coroner  Forensic Nurse Investigator (Death) Crime Scene Investigator	Prison Medical Officer Correctional Nurse  Institutional Psychologist	Police Surgeon ER Physician  Clinical Forensic ER Nurse
Forensic Nurse Consultant (Legal) Forensic Nurse Examiner (Sexual Assault) Forensic Nurse Investigator (Death) Forensic Geriatric Nurse Forensic Pediatric Nurse Forensic Psychiatric Nurse Forensic Educator/Researcher	Forensic Psychiatric Nurse Forensic Social Worker  Court/Judge/Police  Forensic Psychometrist	Criminal Profiler/ Police  Forensic Toxicologist	Correctional Officer Parole/Probation/ Police	Interpersonal Violence Nurse SANE/SART Nurse  EMT/ Paramedic  Police
<b>Forensic Nursing Systems &amp; Services</b>	<b>Forensic Psychiatric Systems &amp; Services</b>	<b>Forensic Medicine Systems &amp; Services</b>	<b>Forensic Corrections Systems &amp; Services</b>	<b>Forensic Clinical ER Systems &amp; Services</b>
Health Care System  Mental Health System Criminal Justice System ME/Coroner System  Gov't approved Services	Mental Health System  Criminal Justice System Forensic Psychiatric Services Forensic Community & Private Services Judicial Legal System	Coroner System  Medical Examiner System Health Care System Solicitor General Services Police Services	Criminal Justice System <i>Mental Health System</i>  Forensic Psychiatric Services Correctional Services Judicial Legal System	Health Care System  Child Welfare System  Emergency Medical Services Judicial Legal System Police Services  SANE/ SART Services

**Focus on Forensic Course Content Index- 5 Topics (cont.)**

<b>Forensic Nursing Practice &amp; Prevention</b>	<b>Forensic Psychiatric Practice &amp; Prevention</b>	<b>Forensic Medicine Practice &amp; Prevention</b>	<b>Forensic Corrections Practice &amp; Prevention</b>	<b>Forensic Clinical ER Practice &amp; Prevention</b>
Standards of Practice Professional Associations Assessment/ Identification/ Screening/Treatment	Standards of Practice Professional Associations Assessment/ Pre-Trial/ Pre- Sentence/ NCR/Dangerous/Risk Fitness/insanity Documentation/ Evidence Collection	Standards of Practice Professional Associations Assessment Sudden/ Accidental/ Unexplained	Standards of Practice Professional Associations Assessment/ Mental Status / Addictions/ Suicide	Standards of Practice Professional Associations Assessment/ Identification/ Screening/ Examinations Wound care / Ballistics
Documentation/ Evidence Collection Therapeutics/ Intervention/ Treatment/Evaluation Medication Management	Documentation/ Evidence Collection Therapeutics/ Intervention/ Treatment/Evaluation Medication Management (Psychotropic)	Documentation/ Evidence Collection Therapeutics/ Intervention/ Treatment/Evaluation Custody of body procedures	Documentation/ Evidence Collection Therapeutics/ Intervention/ Treatment/Evaluation Medication Management (Prison Health)	Documentation/ Evidence Collection Therapeutics/ Intervention/ Treatment/Evaluation Medication Management
Health Prevention/Promotion	Health Prevention/Promotion	Health Prevention/Promotion	Health Prevention/Promotion	Health Prevention/ Promotion



## Focus on Forensic Course Content Index- 5 Topics (cont.)



Forensic Nursing Populations at Risk	Forensic Psychiatric Populations at Risk	Forensic Medicine Populations at Risk	Forensic Corrections Populations at Risk	Forensic Clinical ER Populations at Risk
(Victim/offender/family)	(Mentally Ill offender) Aboriginal / Multicultural Offender	(Deceased) SIDS	(Offender) <b>Aboriginal / Multicultural Offender</b>	(Victims) <b>Child abuse/neglect</b>
<b>Child prostitution/</b>	Addicted Offender Aging Offender Chronically Ill Offender/ HIV Offender	Homicide Drowning Accidental	<b>Addicted Offender Aging Offender Chronically Ill Offender/ HIV Offender</b>	Child sexual abuse Child prostitution/ Female circumcision
<b>Child pornography</b>	<b>Dangerous Offenders</b>	Suicidal	Dangerous Offenders	Munchausen Syndrome by Proxy Shaken Baby Syndrome Families of victims
Families of deceased	Disabled/ Mentally Challenged Offender Families of Offenders Female Offender	Families of patients/victims	<b>Disabled/ Mentally Challenged Offender Families of Offenders</b>	
			<b>Female Offender</b>	<b>Elder/ Senior Abuse Sexual Abuse</b>
<b>Nurse Abuse</b>	<b>Mentally Ill Offender</b> Nurse Abuse <b>Sex Offender</b> Suicidal/ Self Harm Offender Young Offender		Homicidal Filicidal Offenders Mentally Ill Offender Nurse Abuse Sex Offender <b>Suicidal/ Self Harm Offender</b> Young Offender	<b>Spouse Abuse</b> Nurse Abuse

## Focus on Forensic Course Content Index- 5 Topics (cont.)



Forensic Nursing Concepts & Issues	Forensic Psychiatric Concepts & Issues	Forensic Medicine Concepts & Issues	Forensic Corrections Concepts & Issues	Forensic Clinical ER Concepts & Issues
Rights (Human /patient) Media/Technology Issues Violence/ Terrorism/ Rage School/Workplace/Bullying Confidentiality/ Stigma	Rights (Mentally Ill offender) Media/Technology Issues Violence/ Anger / Aggression  Homicide  Filicide	Rights (deceased) Media/Technology Issues Violence/ Intentional Death  DNA  Organ Donation  Toxicology	Rights (offender) Media/Technology Issues Violence Anger / Aggression/  Caring/ Custody  Capital Punishment Deinstitutionalization Recidivism Restraint/Seclusion Suicide Tx vs. Warehousing	Rights (victim) Media/Technology Issues Violence/ Catastrophic/ Bio Chemical/ Terrorism Confidentiality/ Control Organ Donation
Forensic Nursing Future	Forensic Psychiatric Future	Forensic Medicine Future	Forensic Corrections Future	Forensic Clinical ER Future
<b>Education</b> (international) <b>Research</b> (international) <b>Careers</b> (international) ©Kent-Wilkinson, 2002	<b>Education</b> (international) <b>Research</b> (international) <b>Careers</b> (international)	<b>Education</b> (international) <b>Research</b> (international) <b>Careers</b> (international)	(Prison) <b>Education</b> (international) (Prison) <b>Research</b> (international) (Prison) <b>Careers</b> (international)	<b>Education</b> (international) <b>Research</b> (international) <b>Careers</b> (international)

Forensic Practice in Health Care

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## INDEX

## SECTION 0 FORENSIC INTRODUCTION

- Section 0 - Unit 1.1 Course Introduction
- Section 0 - Unit 2.2 Course Description
- Section 0 - Unit 3.3 Course Overview
- Section 0 - Unit 4.4 Course Assignments
- Section 0 - Unit 5.5 Course Writer/Instructor

## SECTION I FORENSIC MEDICINE PRACTICE

- Section 1 - Unit 1.0 Forensic History
- Section 1 - Unit 2.0 Forensic Roles
- Section 1 - Unit 3.0 Forensic Systems/Services
- Section 1 - Unit 4.0 Forensic Practice/Prevention
- Section 1 - Unit 5.0 Forensic Populations
- Section 1 - Unit 6.0 Forensic Concepts/Cases
- Section 1 - Unit 7.0 Forensic Practice Issues
- Section 1 - Unit 8.0 Forensic Future

## SECTION II CLINICAL FORENSIC PRACTICE

- Section 2 - Unit 1.0 Forensic History
- Section 2 - Unit 2.0 Forensic Roles
- Section 2 - Unit 3.0 Forensic Systems/Services
- Section 2 - Unit 4.0 Forensic Practice/Prevention
- Section 2 - Unit 5.0 Forensic Populations
- Section 2 - Unit 6.0 Forensic Concepts/Cases
- Section 2 - Unit 7.0 Forensic Practice Issues
- Section 2 - Unit 8.0 Forensic Future

## SECTION III PRISON HEALTH CARE PRACTICE

- Section 3 - Unit 1.0 Forensic History
- Section 3 - Unit 2.0 Forensic Roles
- Section 3 - Unit 3.0 Forensic Systems/Services
- Section 3 - Unit 4.0 Forensic Practice/Prevention
- Section 3 - Unit 5.0 Forensic Populations
- Section 3 - Unit 6.0 Forensic Concepts/Cases
- Section 3 - Unit 7.0 Forensic Practice Issues
- Section 3 - Unit 8.0 Forensic Future

Forensic Practice in Health Care (cont.)

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## INDEX

## SECTION IV FORENSIC PSYCHIATRIC PRACTICE

- Section 4 - Unit 1.0 Forensic History
- Section 4 - Unit 2.0 Forensic Roles
- Section 4 - Unit 3.0 Forensic Systems/Services
- Section 4 - Unit 4.0 Forensic Practice/Prevention
- Section 4 - Unit 5.0 Forensic Populations
- Section 4 - Unit 6.0 Forensic Concepts/Cases
- Section 4 - Unit 7.0 Forensic Practice Issues
- Section 4 - Unit 8.0 Forensic Future

## SECTION V FORENSIC NURSING PRACTICE

- Section 5 - Unit 1.0 Forensic History
- Section 5 - Unit 2.0 Forensic Roles
- Section 5 - Unit 3.0 Forensic Systems/Services
- Section 5 - Unit 4.0 Forensic Practice/Prevention
- Section 5 - Unit 5.0 Forensic Populations
- Section 5 - Unit 6.0 Forensic Concepts/Cases
- Section 5 - Unit 7.0 Forensic Practice Issues
- Section 5 - Unit 8.0 Forensic Future

- Undergraduate Students may select 3 Sections out of the 5 Sections offered.
- Undergraduate Students should complete as One if their required Three – the Section of their discipline, for example:
  - Nursing students - Section 5 Forensic Nursing
  - Psychology students– Section 4 Forensic Psychiatry
  - Criminology students – Section 3 Prison Health
- Assignments from 3 Sections out of the 5 are required for course completion for undergraduate students
- Assignments from 5 Sections out of the 5 are required for course c

## SECTION A FORENSIC MEDICINE

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Section A -Unit 1.0	Forensic History
Section A-1.1	Historical/Legal/Statistical Timelines .....
Section A -Unit 2.0	Forensic Roles
Section A-2.1	Coroner/Medical Examiner
Section A-2.2	Crime Scene Investigators/Criminal Profiler/Forensic Scientists
Section A-2.3	Nurse Death Investigator .....[Section E-2-1]
Section A-Unit 3.0	Forensic Systems/Services
Section A-3.1	Medical Examiner /Coroner System .....
Section A-Unit 4.0	Forensic Theories / Assessment/ Intervention
Section A-4.1	Crime Scene Evidence.....
Section A-4.2	Custody of the Body Procedure .....
Section A-4.3	Family/Crisis Intervention/Psychosocial.....
Section A-Unit 5.0	Forensic Populations
Section A-5.1	Deaths – Sudden/Undetermined.....
Section A-Unit 6.0	Forensic Concepts/Cases
Section A-6.1	Forensic Toxicology .....
Section A-6.2	Forensic Identification/Ballistics.....
Section A-6.3	DNA .....
Section A-6.4	Fingerprint Analysis.....
Section A-Unit 7.0	Forensic Practice Issues
Section A-7.1	Human Rights/ Invasion of Privacy/Dying Rights.....
Section A-7.2	Organ Donation .....[Section B-7.4]
Section A-Unit 8.0	Forensic Education
Section A-8.1	Forensic Books, Journals, Associations, Conferences, Listservs
Section A-8.1	Forensic Education Courses .....
Section A-Unit 9.0	Forensic Research
Section A-9.1	Forensic Educational Research .....
Section A-9.2	Forensic Practice Research.....
Section A-Unit 10.0	Forensic Future.....
Section A-10.1	Forensic Career Opportunities.....

## SECTION B

## FORENSIC CLINICAL (LIVING ) PRACTICE

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Section B-Unit 1.0	Forensic History
Section B-1.1	Historical/Legal/Statistical Time Lines.....
Section B-1.2	Philosophies/Theories .....
Section B-Unit 2.0	Forensic Roles
Section B-2.1	Police Surgeon.....
Section B-2.2	ER Physician /EMT/Paramedic.....
Section B-2.3	Clinical Forensic Nurse..... [Section E-2.2]
Section B-2.4	Sexual Assault Nurse ..... [Section E-2.3]
Section B-2.5	Expert Witness ..... [Section E-2.5]
Section B-2.6	Legal Nurses Consultant..... [Section E-2.7]
Section B-Unit 3.0	Forensic Systems/Services
Section B-3.1	Health Care System/Child Welfare System....[Section E-3.1]
Section B-Unit 4.0	Forensic Practice/Prevention
Section B-4.1	Sexual Assault Examinations.....
Section B-4.2	Evidence Collection/ Chain of Custody/.....
Section B-4.3	Blunt & Sharp Injury/Gunshot/Wound Analysis.....
Section B-4.4	Forensic Photography.....
Section B-4.5	Family/Crisis Intervention/Psychosocial.....
Section B-4.6	Documentation/Medical Records/Confidentiality .....
Section B-Unit 5.0	Forensic Populations (at Risk)(Living Forensic)
Section B-5.1	Spousal Abuse .....
Section B-5.2	Child Abuse/Neglect.....
Section B-5.3	Child Prostitution.....
Section B-5.4	Senior Abuse/Neglect .....
Section B-5.5	Sexual Abuse Survivors .....
Section B-Unit 6.0	Forensic Concepts/Cases
Section B-6.1	Violence (school, workplace, trauma/disaster).....
Section B-Unit 7.0	Forensic Practice Issues
Section B-7.1	Victim/Patient Rights.....
Section B-7.2	Media/Technology.....[See Section E-7.2]
Section B-7.3	Munchausen Syndrome.....
Section B-7.4	Organ Donation ..... [See Section A-7.2]
Section B-Unit 8.0	Forensic Education
Section B-8.1	Forensic Books, Journals, Associations, Conferences, Listservs
Section B-8.1	Forensic Education Courses .....
Section B-Unit 9.0	Forensic Research
Section B-9.1	Forensic Educational Research .....
Section B-9.2	Forensic Practice Research.....
Section B-Unit 10.0	Forensic Future.....
Section B-10.1	Forensic Career Opportunities.....

## SECTION C

## FORENSIC CORRECTIONS / PRISON HEALTH CARE

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Section C-Unit 1.0	Forensic History
Section C-1.1	Historical/Legal/Statistical Time Lines.....
Section C-1.2	Prison Philosophies/Theories .....
Section C-Unit 2.0	Forensic Roles
Section C-2.1	Prison Medical Officer.....
Section C-2.2	Correctional Health Care Officer .....
Section C-2.3	Institutional Psychologist .....[See Section D-2.2]
Section C-2.4	Correctional Nurse .....[See Section E-2.4]
Section C-Unit 3.0	Forensic Systems/Services
Section C-3.1	Criminal Justice System.....
Section C- Unit 4.0	Forensic Practice/Prevention
Section C-4.1	Chronic Illness Intervention.....
Section C-4.2	AIDS/HIV/Hepatitis/TB.....
Section C-4.3	Addictions Assessment .....
Section C-4.4	Suicidal/Self Harm .....
Section C-4.5	Family/Crisis Intervention/Psychosocial.....
Section C- Unit 5.0	Forensic Populations
Section C-5.1	Aging Offender .....
Section C-5.2	Female Offender .....
Section C-5.3	Native Offender .....
Section C-5.4	Young Offenders .....
Section C- Unit 6.0	Forensic Concepts/Cases
Section C-6.1	Custody /Caring .....
Section C-6.2	Deinstitutionalization .....
Section C- Unit 7.0	Forensic Practice Issues
Section C-7.1	Offender Rights .....
Section C-7.2	Treatment verses Warehousing .....
Section C-7.3	Recidivism/Frequent Flyer .....
Section C-7.4	Capital Punishment .....
Section C- Unit 8.0	Forensic Education
Section C-8.1	Forensic Books, Journals, Associations, Conferences, Listservs
Section C-8.1	Forensic Education Courses .....
Section C- Unit 9.0	Forensic Research
Section C-9.1	Forensic Educational Research .....
Section C-9.2	Forensic Practice Research.....
Section C- Unit 10.0	Forensic Future.....
Section C-10.1	Forensic Career Opportunities.....

## SECTION D FORENSIC PSYCHIATRY

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Section D- Unit 1.0	Forensic History
Section D-1.1	Historical/Legal/Statistical Time Lines.....
Section D-1.2	Philosophies/Theories .....
Section D-Unit 2.0	Forensic Roles
Section D-2.1	Forensic Psychiatrist .....
Section D-2.2	Forensic Psychologist .....
Section D-2.3	Forensic Occupational /Recreational Therapist .....
Section D-2.4	Forensic Social Worker .....
Section D-2.5	Forensic Psychiatric Nurse.....[Section E-2-5]
Section D-Unit 3.0	Forensic Systems/Services
Section D-3.1	Forensic Psych/Mental Health Care System/Services.....
Section D-3.2	Forensic Community Psych/Mental Health Care System/Services
Section D-3.3	Forensic Private Systems/Services.....
Section D-Unit 4.0	Forensic Practice/Prevention
Section D-4.1	Pre-Trial/Pre-Sentence/Fitness/Responsibility Assessment.....
Section D-4.2	Dangerous Offender Risk/Parole Assessment .....
Section D-4.3	Family/Crisis Intervention/Psychosocial.....
Section D-4.4	Documentation/Medical Records/Confidentiality .....
Section D-Unit 5.0	Forensic Populations
Section D-5.1	Mentally Ill Offender .....
Section D-5.2	Sex Offenders .....
Section D-5.3	Disabled/ Mentally Challenged Offender.....
Section D-Unit 6.0	Forensic Concepts/Cases
Section D-6.1	Violence (anger/aggression).....
Section D-6.2	Homicide (single/serial/mass).....
Section D-6.3	Infanticide (felicide/ neonaticide).....
Section D-6.4	Nurses Who Kill.....
Section D-6.5	Spousal Homicide.....
Section D-Unit 7.0	Forensic Practice Issues
Section D-7.1	Restraint/Seclusion.....
Section D-7.2	Media Technology Issues.....[See Section E-7.2]
Section D-Unit 8.0	Forensic Education
Section D-8.1	Forensic Books, Journals, Associations, Conferences, Listservs
Section D-8.1	Forensic Education Courses .....
Section D-Unit 9.0	Forensic Research
Section D-9.1	Forensic Educational Research .....
Section D-9.2	Forensic Practice Research.....
Section D-Unit 10.0	Forensic Future.....
Section D-10.1	Forensic Career Opportunities.....



## SECTION E

## FORENSIC NURSING

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Section E-Unit 1.0	Forensic History
Section E-1.1	Historical/Legal/Statistical Time Lines.....
Section E-1.2	Philosophies/Theories .....
Section E-Unit 2.0	Forensic Roles
Section E-2.1	Nurse Death Investigator .....[Section A-2.3]
Section E-2.2	Clinical Forensic Nurse .....[Section B-2.4]
Section E-2.3	Sexual Assault Nurse .....[Section B-2.5]
Section E-2.4	Correctional Nurse .....[Section C-2.4]
Section E-2.5	Forensic Psychiatric Nurse .....[Section D-2.5]
Section E-2.6	Expert Witness .....[Section B-2.6]
Section E-2.7	Legal Nurse Consultant/ Independent Practice[Section B-2.7]
Section E-Unit 3.0	Forensic Systems/Services
Section E-3.1	Medical Examiner/Coroner System .....[Section A-3.1]
Section E-3.2	Health Care System/Child Welfare System ..[Section B-3.1]
Section E-3.3	Criminal Justice System ..... [Section C-3.1]
Section E-3.4	Forensic Psych/Mental Health Care System/Services .... [Section D-3.1]
Section E-3.5	Forensic Community Psych/Mental Health System/Services [Section D-3.2]
Section E-3.6	Forensic Private Systems / Services.....[Section D-3.3]
Section E-Unit 4.0	Forensic Practice/Prevention
Section E-4.1	Standards of Practice .....
Section E-4.2	Professional Associations .....
Section E-4.3	Family/Crisis Intervention/Psychosocial.....
Section E-4.4	Documentation/Medical Records/Confidentiality .....
Section E-Unit 5.0	Forensic Populations (at Risk)
Section E-5.1	Nurse Abuse .....
Section E-5.2	Harassment (Sexual)/ Stalking.....
Section E-Unit 6.0	Forensic Concepts/Case Studies
Section E-6.1	Shaken Baby Syndrome .....
	Case #1 British Au pair Nanny .....
	Case #2 Arizona Avondale Quintuplets.....
Section E-Unit 7.0	Forensic Practice Issues
Section E-7.1	Human Rights / International Issues .....
Section E-7.2	Media/Technology Pornography Issues [Section B-7.2][Section D-7.2]
Section E-7.3	Female Circumcision .....
Section E-7.4	Euthanasia/Physician Assisted Suicide.....

## SECTION E

FORENSIC NURSING (cont.)

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Section E-Unit 8.0	Forensic Education
Section E-8.1	Forensic Books, Journals, Associations, Conferences, Listservs
Section E-8.1	Forensic Education Courses .....
Section E-Unit 9.0	Forensic Research
Section E-9.1	Forensic Educational Research .....
Section E-9.2	Forensic Practice Research.....
Section E-Unit 10.0	Forensic Future
Section E-10.1	Forensic Career Opportunities.....

## APPENDIX D DATA COLLECTION TABLES

## Appendix D1

## Participant Schedule 2006

Participant # Number & Country	Date Email Info Sent	Date Email Survey Ret'd	Date course Docs Rec'd	Date Email To set Phone date sent	Date Phone Interview Consent Rec'd	Date of Phone Interview	Date Transcript Sent to participant	Date Consent for transcr't release Rec'd
P01CA	06/01/24	06/01/27	06/01/27	06/01/24	06/01/27	06/01/27 110 min	06/02/15	06/09/29
P02CA	06/02/04	06/02/14	06/02/20	06/02/14	06/02/20	06/02/05 35min	06/02/14	06/09/29
P03US	06/02/04	06/02/04	06/02/04	06/02/05	06/02/04	06/02/29 1315- 1410 55 min	06/02/18	06/09/29
P04AU	06/02/04		06/02/04			06/02/12 40 min		
P05US	06/02/08	06/07/26 1300 hrs	06/07/26	06/07/26	Email 06/07/26	06/07/26 1300 hrs	06/08/06	06/09/29
P06US	06/02/16					06/05/19	06/06/18	06/09/29
P07US	06/10/2	06/10/13	06/10/13	06/10/13	06/11/01	06/11/09	06/11/16	06/09/29
P08US	06/02/16 06/07/18 06/07/25					06/08/05 1000	06/08/16	06/09/29
P09CA	06/02/16	06/03/03	06/06/08	06/04/20		06/04/27 1100 1000 her time	06/05/07	06/09/29
P10	06/02/21	Phone interview 06/03/26	06/05/20	06/03/26	06/09/29	Mar 26 0900 EST 70 min	06/04/16	06/04/18
P11	06/02/22 06/04/23	06/04/27	06/05/29 UC	06/04/27	06/04/27	06/04/27	06/05/13	06/09/29
P12CA	06/03/01	06/03/30		06/03/30	06/04/10	06/04/10	06/05/06	29/9/06
P13CA	06/03/16	06/03/21		06/03/21	06/03/21	06/03/23 20 min	Admin Not included	
P14US	06/03/16 June 23 Jul 25	06/08/28		06/08/28	06/08/28			
P15US	06/05/15	06/05/26	06/06/05	06/05/28	06/05/28	06/06/01	06/06/22	06/07/28
P16US	06/05/15 06/07/18	06/07/18			06/07/18	06/09/15	06/09/17	
P17US	06/05/29 06/06/23	06/07/10			XXXXXXX	06/07/25 1100 hrs		06/09/29
P18US	06/05/30 Called 06/06/23							
P19US	06/07/24	06/08/02		06/08/02	06/08/20	06/08/05	06/08/20	06/08/20
P20US	06/08/01	06/08/14		06/08/14		06/08/21	06/08/23	06/09/29

## Appendix D2

## Title of Courses Educators Developed (S6)

S6.	How many forensic nursing courses have you developed? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> specify Please list the titles of the Courses:	
<i>Participant</i>	<i>Number</i>	<i>List Titles</i>
P01	1 + 1 in progress	NURS 486 -- Forensic Nursing in Secure Environments (post registration BSN elective course) NURS 895 – Advanced Forensic Mental Health (graduate nursing elective course – development in progress) Plus supervised students in clinical practice undergraduate and graduate
P02	4	Victims of Violence Forensic Science Sexual Assault Evaluation & Intervention Theory Sexual Assault Evaluation & Intervention Clinical
P03	5	Holistic Forensic Nursing I Holistic Forensic Nursing II Holistic Forensic Nursing III Disaster Management... Sexual Assault Nurse Examiner Training {SANE}
P05	3	Issues in Forensic Nursing Interpersonal Violence Forensic Nursing Practicum and Seminar
P06	5	Introduction to Forensic Nursing Forensic Nursing Care of Perpetrators Scientific Foundations of Forensic Nursing Nursing with Diverse Populations – Forensic Clients Forensic Nursing Practicum
P07	6	Crisis theory and intervention Assessment of the forensic client The Legal System Nursing of Populations I: Forensic Nursing of Populations II: Forensic Nursing Practicum: Forensic
P08	6	Beth el College Introduction to Forensic Nursing Forensic Nursing science (graduate level) Sexual assault Training Violence and human rights Legal Course International

## Appendix D2 (Cont.)

## Title of Courses Educators Developed (S6)

P09	6	Forensic Nurse Examiner Core Education Introduction to Forensic Health Sciences Wound and Injury Assessment Documentation and Evaluation Clinical Management of the Victims of Crime Violence and Trauma
P10	4	1. Introduction to Forensic nursing 2. Introduction to correctional nursing 3. Intro to clinical practice of correctional nursing, 4. Introduction to forensic psych
P11	7	Introduction to Forensic Nursing, Clinical Forensic Nursing and Hospital Risk Management Forensic Photography for Nurses Occupational Health and the Forensic Nurse Courtroom Testimony for Forensic Nurses Forensic Nursing for Emergency Nurses JCAHO Regulatory Requirements related to Forensic Nursing
P12	1	Sexual Assault Nurse Examiner Training in Ontario
P14	7	5 courses in the DNP program and 2 continuing Ed
P15	3	Victimology Forensic Science Forensic Mental Health
P16	4	Fundamentals of Forensic Nursing Advanced Forensic Nursing Family Violence Specialty Practicum – Clinical Forensic Nursing
P17	3	GNFOR 500 Introduction to Forensic Nursing and Health GNFOR 501 Advanced Practice Forensic Nursing GNFOR 502 Forensic Clinical GNFOR 503 Overview of the Legal System (Module 1) GNFOR 504 Functions of the Forensic Scientist and the Forensic Science Professional (Module 2) GNFOR 505 Criminal Law and Forensic Scientific Procedures (Module 3) GNFOR 506 Civil Applications of Forensic Science (Module 4) GNFOR 507 Trial Preparation and Tactics and General Evidentiary Considerations (Module 5) GNFOR 508 Independent Study: Research and Writing Annual Conference (Module 6)

## Appendix D2 (Cont.)

## Title of Courses Educators Developed (S6)

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P19		5+++	CEU courses - TNTC on a variety of topics SANE course many times I have developed SANE courses for states (North Carolina, Kentucky, Tennessee, Georgia, Alabama, and others) where universities, state organizations, or government bodies within the state have used my coursework... so I guess it fits!
P20		30	Do you want the titles of all the courses SANE training Basic 40 hrs SANE Training Advanced – 2 day Counseling SA Victims 2-day Plus many counseling /partial course based on the above #20 and others are all SANE courses, different course but all SANE
Total	n=17	88+	
Range		1-30	30 is all SANE
RANGE		1-7	Different courses

---

## Appendix D3

## Year Forensic Nursing Course First Offered

S16                      What year was your Forensic Nursing Course/Program first offered at your university/college?

Participant	Year
P01	2003
P02	1997 Jan
P03	1999 PILOT
P05	2001
P06	1995 or 1996
P07	2003
P08	1992
P09	2005 January
P10	1991??
P11	1994
P12	1995
P14	2001
P15	Early 1990's
P16	2001
P17	2002
P19	1988 information about forensic nursing and treatment of victims was offered, the first formal course in forensic nursing was not until 2002
P20	There is none
Total	N=17
Range	1992-2005

## Appendix D4

## Titles of Courses at Your Institution (S17)

S17. What is/was the number, name and title of the forensic course/program at your institution?

Examples: FORE 4401: Health care in forensic populations  
NURS 475.3: Forensic nursing in multiple environments

<i>Participant</i>	<i>Type</i>	<i>Number and Title</i>
P01	Behavioral	NURS 486.3 Forensic Nursing in Secure Environments NURS 895 – Advanced Forensic Mental Health (graduate nursing elective course – development in progress)
P02	Both Intro	FORE 4401 – Forensic history, risk populations & issues (3 cr) FORE 4403- Forensic psychiatric & correctional populations (3 cr) FORE 4405- Victims of violence (3 cr) FORE 4407- Forensic science (3 cr) FORE 4409- Expert witness testimony (3 cr) FORE 4411- Crime scene investigation & evidence collection (3 cr) FORE 4413- Sexual assault evaluation & intervention (theory) (3 cr) FORE 4415- Sexual assault evaluation & intervention (clinical) (3 cr)
P03	?	Holistic Forensic Nursing I Holistic Forensic Nursing II Holistic Forensic Nursing III Disaster Management... Sexual Assault Nurse Examiner Training {SANE}
P05	For Sc	NU 575 Issues in Forensic Nursing; NU 578 Forensic Nursing Practicum and Seminar; NU576 Interpersonal Violence.....
P06	Intro Both	NURS 8000 Introduction to Forensic Nursing 3 S.H. NURS 8130 *Scientific Foundations for Forensic Nursing Interventions 3 S.H. NURS 8200 *Forensic Nursing: Caring for Victims and Perpetrators I 3 S.H. NURS 8300 *Forensic Nursing: Caring for Victims and Perpetrators II 3 S.H. NURS 9500 *Practicum in Forensic Nursing 3 S.H.
P07	Intro ?	NUR 511 Introduction to forensic nursing: Crisis theory & intervention NUR 512 Forensic Assessment NUR 614 Population Health Nursing I: Forensic NUR 615 Population Health Nursing II: Forensic NUR 617 Legal System
P08	Intro ?	HSCI 429/NURS 636 Legal Aspects of Forensic Science: Civil & Criminal HSCI 430/NURS 630 Sexual Assault: Implications for Health Care Delivery HSCI 431/NURS 631 Introduction to Forensic Nursing & Health Sciences HSCI 432/NURS 632 Investigation of Injury and Death HSCI 433/NURS 633 Crime Scene and Crime Lab HSCI 434/NURS 634 Psychosocial and Legal Aspects of Forensic Sc HSCI 437/NURS 637 Violence & Human Rights Issues



## Appendix D4 (cont.)

## Titles of Courses at Your Institution (S17)

	Intro For Sc	FSCT 7320 Introduction to Forensic Science FSCT 7820 Management of Victims of Trauma, Violence and Crime FSCT 7830 Wounds and Injuries: Assessment, Documentation and Evaluation FSCT 7840 Sexual Assault Nurse Examiner Core Education – Theoretical Aspects
P09 P10	?	Can't remember course number at IU Thinks it is 4360 at LSU nursing. Yes the word "Nursing" was in the title
P11	Intro For Sc	Unknown for past courses; current courses: X465.0 Introduction to Forensic Nursing: X465.3 Forensic Approaches to Human Abuse Injuries X465.4 Forensic Approaches to Occupational Injuries and Emergency Response X 465.7 Forensic Photography in the Healthcare Setting
P12	?	Provincial Sexual Assault Course
P14	For Sci	2 of the 5 Nursing is not in the title Injury among Individuals Injury among Populations
P15	Both	Nursing 333/533 Victimology; 334/534 Forensic Science; 331/531 Forensic Mental Health
P16	Intro For Sci	NR100.628/428 Fundamentals of Forensic Nursing NR 593/493 Family Violence NR100.633 Advanced Forensic Nursing NR110.521 Specialty Practicum II – Clinical Forensic Nursing
P17	Intro ?	GNFOR Introduction to Forensic Nursing and Health GNFOR Advanced Practice Forensic Nursing GNFOR Forensic Clinical
P19	For Sci	Again, my programs were integrated into existing programs, like community health or OB-GYN, or Primary Care I, II, & III.....
P20	For Sc	N/A
n=17		

- Many variables
- 8/17 offered an Introductory Course
- 2/17 clearly offered both a Forensic Science and Forensic Behavioral Sciences
- 7/17 offered only Forensic Science courses
- 1/17 offered only Forensic Behavioral Sciences
- 7/17 of the course titles it was difficult to determine

## Appendix D5

## Taxonomy Knowledge Concepts to Include (111) (5.10)

<i>From 5.10</i>	<i>Taxonomy Knowledge Concepts to Include (111 concepts)</i>
<ul style="list-style-type: none"> <li>• Abuse, neglect</li> <li>• Accidents</li> <li>• Accident reconstruction</li> <li>• Accountable</li> <li>• Accurate documentation</li> <li>• Aggression</li> <li>• Anger</li> <li>• Assessment (physiological domain, role of violence)</li> <li>• Assessment (risk, sexual assault, forensic psychiatric, fitness, competency)</li> <li>• Boundary violations</li> <li>• Caring (24 hr care, continuous, coordinator of) (See 'Forensic Care' typology)</li> <li>• Caring and custody</li> <li>• Case work</li> <li>• Cause, manner &amp; mechanism of death</li> <li>• Chain of custody</li> <li>• Clinical photography</li> <li>• Collection of evidence</li> <li>• Colposcope</li> <li>• Consent</li> <li>• Control</li> <li>• Core competencies (IAFN)</li> <li>• Counseling (individual and group)</li> <li>• Countertransference</li> <li>• Court room testimony*</li> <li>• Crime scene</li> <li>• Criminal behavior</li> <li>• Criminal Code</li> <li>• Criminal intent</li> <li>• Criminalistics</li> <li>• Crisis intervention</li> <li>• Cultural diversity</li> <li>• Documentation</li> <li>• Domestic violence</li> <li>• Elder abuse</li> <li>• Environment (special)</li> <li>• Ethics (code)</li> <li>• Evidence (cross transference, forensic, general)</li> <li>• Evidentiary collection (principles of, and management of)</li> </ul>	<ul style="list-style-type: none"> <li>• Focus (See Forensic Focus typology)</li> <li>• Forensic (See Forensic prefix typology)</li> <li>• Forensic epidemiology</li> <li>• Forensic evidence</li> <li>• Forensic Populations (vulnerable) (See Forensic Population typology)</li> <li>• Forensic Clients (offenders)</li> <li>• Forensic mental health</li> <li>• Forensic psychiatric assessment</li> <li>• Forensic science</li> <li>• Forensic Science - collection of evidence, principles of evidentiary collection</li> <li>• Forensic Science (DNA, evidence collection, issues of the law)</li> <li>• Forensic Services (See Forensic System/Services typology)</li> <li>• Forensic toxicology</li> <li>• Global</li> <li>• Healing</li> <li>• Health</li> <li>• Historical overview of emerging roles</li> <li>• Holistic approach</li> <li>• Homicide (familial, spousal)</li> <li>• Holism</li> <li>• Human rights</li> <li>• Identifies and investigates clinical events</li> <li>• Illness prevention</li> <li>• Injury (intentional, non-intentional)</li> <li>• Injury (harm, mechanics of ,impact of invasive)</li> <li>• International</li> <li>• Investigation (steps, analysis)</li> <li>• Investigative and evidentiary management</li> <li>• Intersectoral collaboration</li> <li>• Interdisciplinary collaboration</li> <li>• Interpersonal Violence</li> <li>• Issue (malpractice)</li> <li>• Justice</li> <li>• Laws &amp; Acts</li> <li>• Legal (issues, systems, process, liability, terminology)</li> <li>• Legal system (knowledge of)</li> <li>• Living patients</li> </ul>

## Appendix D5 (cont.)

## Taxonomy Knowledge Concepts to Include (111) (5.10)

*Table 5.10 Taxonomy 5.10 Knowledge Concepts to Include (111) (cont.)*

<ul style="list-style-type: none"> <li>• Manner, method, &amp; mode of death</li> <li>• Malpractice issue</li> <li>• Medication (administration, supervision, evaluation, impact of)</li> <li>• Medication management</li> <li>• Medico-legal</li> <li>• Nursing</li> <li>• Offender Rights</li> <li>• Oral presentation for court room testimony</li> <li>• Other (othering)</li> <li>• Patient safety</li> <li>• Perpetrator behavior</li> <li>• Person</li> <li>• Populations at risk</li> <li>• Preventive intervention for offenders</li> <li>• Photography (Clinical)</li> <li>• Physiological &amp; psychological effects of trauma on victims</li> <li>• Populations (marginal, risk, special, unique, vulnerable)</li> <li>• Power and Control</li> <li>• Practice (standards )</li> <li>• Primary health care</li> <li>• Psych mental health</li> <li>• Research</li> <li>• Rape trauma syndrome</li> <li>• Responsible</li> <li>• Restraint</li> </ul>	<ul style="list-style-type: none"> <li>• Risk assessment</li> <li>• Risk management and quality control</li> <li>• Role of forensic evidence</li> <li>• Role of the different professionals</li> <li>• Seclusion</li> <li>• Security</li> <li>• Sex offender treatment program</li> <li>• Sexually assaulted adult and child</li> <li>• Services (forensic psychiatric, correctional institutions, prisons)</li> <li>• Systems (criminal justice, education, health care, medical examiner, coroner, mental health care) [See 'Forensic System/Services' typology]</li> <li>• System (individual, group, family, community)</li> <li>• Toluidine Blue</li> <li>• Trauma (impact of)</li> <li>• Unique (See Unique Prefix typology)</li> <li>• Victim Rights</li> <li>• Violation</li> <li>• Violence (dynamics of)</li> <li>• Violence (Prevention, Intervention, Theories)</li> <li>• Violence</li> <li>• Violent behavior</li> <li>• Wounding</li> </ul>
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## Appendix D5 (cont.)

## Taxonomy Knowledge Concepts to Include (111) (5.10)

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*Taxonomy 5.10 Knowledge Concepts to Include*

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<i>Knowledge from other disciplines (13)</i>	<i>Forensic Roles (19)</i>	<i>Theories (16)</i>
<ul style="list-style-type: none"> <li>• Behavioral sciences</li> <li>• Criminology</li> <li>• Epidemiology</li> <li>• Forensic chemistry</li> <li>• Forensic mental health</li> <li>• Forensic psychology</li> <li>• Forensic science</li> <li>• Forensic toxicology</li> <li>• Psychiatry</li> <li>• Psych/ mental health</li> <li>• Sociology</li> <li>• Technology</li> <li>• Victimology</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate</li> <li>• Coroner</li> <li>• Correctional officer</li> <li>• Crown</li> <li>• Defence</li> <li>• Expert Witnesses</li> <li>• Forensic psychiatrists</li> <li>• Forensic psychologists</li> <li>• Judge</li> <li>• Lawyers</li> <li>• Medical examiner</li> <li>• Parole/Probation Officer</li> <li>• Police</li> <li>• Forensic Scientists</li> <li>• Forensic Sociologists</li> <li>• Forensic Toxicologist</li> <li>• Forensic pathologist</li> <li>• Physician (ER)</li> <li>• Security Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Adaptation theory</li> <li>• Benner</li> <li>• Boundary theory</li> <li>• Criminology theories</li> <li>• Crisis theory</li> <li>• Feminist theory</li> <li>• Group theories</li> <li>• Learned helplessness</li> <li>• Newman</li> <li>• Nightingale</li> <li>• Peplau</li> <li>• Perpetrator theory</li> <li>• Role theory</li> <li>• Roy</li> <li>• Social learning theory</li> <li>• Social isolation theory</li> <li>• Sociological theories</li> <li>• Stockholm syndrome</li> <li>• Systems theory</li> <li>• Theories of crime</li> <li>• Theories of violence</li> <li>• Victimology</li> </ul>

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## Appendix D5 (cont.)

## Taxonomy Knowledge Concepts to Include (111) (5.10)

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*Taxonomy 5.10**Knowledge Concepts to Include (cont.)*

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*Courses (See Appendix D – S6 and S17) (13)*

- Introductory Course
- Court Testimony Course
- Crime scene and evidence course
- Death investigation medical examiner's course
- Forensic Issues Course
- Legal nurse consultant
- Offender's course
- Perpetrator behavior
- Forensic psychiatry and corrections course
- SANE
- Victims Course
- Nursing generalist program
- Generalist track

*Services (9)*

- forensic psychiatric hospital
- forensic psychiatric unit in general hospital
- correctional institution
- emergency department
- hospital
- jails
- medium secure units
- prisons
- sexual assault clinic

*Frameworks (7)*

- Advanced Practice Forensic Nursing Model
- Expanded Nursing Practice Model
- Multidisciplinary Practice model
- Nursing Framework with Forensic Science Extension
- Population Health Model
- Public Health Model
- WHEEL (wounding, healing, evidence, ethics, legal)

*Graduate level*

- Advance practice nurses
- Clinical nurse specialist
- Critical inquiry
- Leadership
- Research
- Theory development

## Appendix E1

## Phase Ia--Summary of Educators Demographics, S1-8.

*Summary of Educators Demographics, S1-8.*


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*\*indicated highest frequency (n=17); nominal/ordinal data, S=Survey*

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**S1. Demographics**

- \*United States, n =13/17(76.5%)
- Canada, n = 04/17 (23.5%)
- \*Female, n =16/17 (94.1%)
- Male n =01/17 (5.9%)

**S2. Highest level of education**

- \* Doctoral prepared, n = 11/17 (64.7%)
- Doctoral candidate, n = 3/17 (17.7%)
- Masters prepared, n = 2/17 (11.8%)
- Baccalaureate prepared, n = 1/17 (5.9%)

**S3. Clinical experience:**

- Nursing practice* (1-35 yrs)
- Forensic nursing practice* (0-29 yrs)

**S4. Main focus area of nursing**

- \*Emergency, n=6/17 (35.3%)
- Psych/mental health n=3/17 (17.7%)
- Maternal health, n=3/17(17.7%)
- Forensic nursing only, n=2/17 (11.8%)
- Gerontology, n=1/17 (5.9%)
- Public health, n=1/17 (5.9%)
- Child /pediatric, n=1/17 (5.9%)

**S4 (cont). Main focus area of forensic nursing**

- \*Sexual assault nurse examiners, n =7/17 (41.2%)
- Forensic nursing (multiple), n=2/17 (11.8%)
- Forensic psych/corrections, n=2/17 (11.8%)
- Interpersonal violence, n=2/17 (11.8%)
- Clinical forensic, n=1/17 (5.9%)
- Death investigator, n=1/17 (5.9%)
- Injury prevention, n=1/17 (5.9%)
- Product liability, n=1/17 (5.9%)

**S5. Forensic related courses taken for credit**

n = 14/17 (82.4%)

**Forensic nursing courses taken for credit**

n = 12/17 (70.6%)

**S6. Number of forensic courses developed**

(Each 1-30) (Total 88 plus)

**S7. Current Positions**

- \*Most full time faculty, (n=14/17) (82.4%)
- Many program directors
- \*Most significant, n =7/17 (41.2 %) were not on faculty initially

**S8. Teaching experience**

- Nursing (0-42 years)
  - Forensic nursing (3-29 years)
- 

Summary from the email survey, 2008

## Appendix E2

## Phase Ib--Summary of Course Statistics, S9-S21

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*Summary of Course Statistics, S9-S21**\*indicated highest frequency (n=17), Nominal/ordinal data, S=Survey*

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**S9. Type of Educational Institution**

- \*University, n = 12/23 (52.2%)
- College, n = 5/23 (21.7%)
- Other (SANE, hospitals) n = 5/23 (21.7%)

**S10. Needs assessment**

- \*Yes, n=12/17 (70.6%) prior to course development

**S11. Educational Level of Course/Program**

- Certificate level, n=7/26 (26.9%)
- Undergraduate, n=6/26 (23.1%)
- \*Graduate, n=10/26 (38.5%)
- Doctoral, n=2/26 (7.7%)
- Other (hospital/ non credit). n=1/26 (3.8%)

**S12. Pre-Requisite**

- \*Yes, n =9/17 (52.9%)

**S13. Student Discipline**

- Nursing only \* n = 10/17 (58.8%)
- Nursing & other disciplines, n = 7/17 (41.2%)

**S14. Mode of Delivery**

- \*Classroom, n=10/24 (41.6%)
- Web based, n=9/24 (37.5%)
- Hybrid, n=4/24 (16.7%)
- Distance, n=1/24 (4.2%)

**S15. Clinical Component**

- Yes (SANE\*\*) n = 13/17 (76.5%)

**S16. Year Course Started**

- (Range 1977-2005)
- 1977 SANE
- 1988 Con Ed Medicine
- 1994 Nursing
- 1995 Con Ed Nursing

**S17. Types of Forensic Nursing Courses Developed**

- \*Introductory course, n = 8/17 (47.1%)
- Both forensic science/forensic behavioural sciences, n = 2/17 (11.8%)
- \*Only forensic science courses, n = 7/17 (41.2%)
- Only forensic behavioral sc, n = 1/17 (5.9%)
- Difficult to determine, n = 7/17 (41.2%)

**S18. Elective Options(Nursing Program)**

- 2 electives, n=3/19 (15.8%)
- \*1 elective, n=7/19 (36.8%)
- 0 electives, n=3/19 (15.8%)
- Unsure, n=4/19 (21.1%)
- N/a (SANE), n=2/19 (10.5%)

**Required/Elective (Forensic Courses)**

- \*Required, n = 9/19 (47.4%)
- Elective, n = 7/19 (36.8%)
- N/a as non credit SANE, n = 3/19 (15.8%)

**S19. Number of Semesters offered**

- \*1 semester a year, n = 7/19 (36.8%)
- 2 semesters a year, n = 6/19 (31.6%)
- 3 semesters a year, (n=1/19) (5.3%)
- N/a as SANE courses, n=5/19 (26.3%)

**S20. Average Number of Students/Year**

- registered (Range 5-100+)

**S21. Comments**

- Curriculums full, no room for Electives. (S21-P01)
- Needed recognition of SANE for university credit. (S21-P12)

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(Summary from the Email Survey, 2008)

## Appendix E3

## Summary of Analysis of Qualitative Interview Responses

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*Summary of Analysis of Qualitative Interview Responses (Q1-13)*

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*Q1. Forensic Nursing defined?*

- Forensic nursing is:
- Forensic nursing is not:
- Forensic nursing is influenced by:
- Forensic nursing is a combination of:
- Forensic nursing is different from:
- Forensic nursing was:
- Forensic is:
- Nursing is:
- Medicine is:

*Forensic Nursing defined?*

- is: (Knowledge DEFINITION theme)  
(CO-CREATED/CO-CONSTRUCTED)
- is not: (ANTITHESES)
- is influenced by: (Knowledge DEVELOPMENT theme)  
(Constructivism – It depends)
- is a combination of: (Knowledge DUAL ROLES theme)  
(Constructivism – both/and; not only/but also)
- is different from: (Knowledge DIFFERENTIAL theme)
- was: (Knowledge HISTORY theme)
- Forensic is: (Knowledge DELINEATION theme)
- Nursing is: (Knowledge DEMARCATION theme)
- Medicine is: (Knowledge DEMARCATION theme)

*Results:* Co-created /constructed definition:



## Appendix E3 (cont.)

## Summary of Analysis of Qualitative Interview Responses

*Q2. Conceptualization?*

- The conceptualization of forensic nursing is:
- The conceptualization of forensic nursing is not:
- The conceptualization of forensic nursing is a combination of:
- The conceptualization of forensic nursing is influenced by:
- The conceptualization of forensic nursing was:

*Results - Conceptualization?*

The conceptualization of forensic nursing is:

- Focus (Main, primary) Nursing
- Focus (Broad, general)
- Focus (Multidisciplinary)
- Focus (legal aspects of nursing practice)

The conceptualization of forensic nursing is not:

- Just technical knowledge
- Just the forensic part

The conceptualization of forensic nursing is a combination of:

- Not only/but also; Both/and
- Not only the forensic sciences but also the forensic behavioral sciences
- Both nursing forensic nursing art and forensic nursing science

The conceptualization of forensic nursing is influenced by:

- affiliations, partners
- personal clinical experience

*Q3. Philosophy of Course?*

- Nursing as the foundation

*Q4. Philosophy of Program?*

- S/A School of Nursing

*Q5. Unique knowledge?*

- What is the unique knowledge of forensic nursing?
- What is this unique knowledge different from nursing in general?
- What is this unique knowledge different from other forensic disciplines?

*What is the unique knowledge of Forensic (92)*

- Forensic Laws and Acts
- Forensic Issues
- Forensic Roles/ Specialties
- Forensic Populations:
- Forensic Services and Systems

## Appendix E3 (cont.)

## Summary of Analysis of Qualitative Interview Responses

*What is this unique knowledge, unique roles or tasks different from nursing in general?*

Differentiation part of the Definition from Data Extracts

- Care of patients (clients) who are victims and offenders on a continuous basis
- Principles of evidentiary collection, preserving chain of custody, and significance of accurate documentation, and court room testimony
- Assessments: risk, criminal responsibility, physical assessments & exams.
- More likely that case & documentation will end up in court; more likely to rely on the knowledge from law & forensic science.
- Different focus to the interview, what someone else did to them, or why offender did what he did; practice with a different group of collaborators in relationship to the patient; prepared differently; addition of knowledge from law, forensic science, criminology etc; provide care in different environments, systems & services to different or special populations; and what was different about this expanded role was that the physician was no longer involved.

*Unique knowledge of forensic nursing that is different from other forensic disciplines?*

*Data Extracts*

- Nursing's holistic & objective approach
- Objective care of victims and perpetrators
- Philosophy or paradigm of care
- Knowledge of systems
- Medication management & administration
- Social sense of continuity of care
- Therapeutic contact is maintained
- Coordinator of team and of patient care
- Dual role of health and healing
- Dual role of custody & caring
- Focus not only on the injury but also on the role of violence in the injury and how that impacts the patient
- Assessments (physiological domain) done *by nurse (in place of the physician)*

## Appendix E3 (cont.)

## Summary of Analysis of Qualitative Interview Responses

Dual roles of:

- *Both care and custody*
- *Both care and collection of evidence*
- *Both care and court room testimony*
- *Both care & chain of custody*
- *Both care and collaborator/coordinator*

NB. Differences are what are different about nursing and other disciplines except for dual roles of forensic nursing:

*Q6. Where educators gained their knowledge? (mixed methods)*

- n = 16/16 - personal clinical experience
- n = 03/16 - clinical teaching supervising students
- n = 11/16 - professional clinical practice experts
- n = 11/16 - literature publications
- n = 06/16 - forensic disciplines
- n = 06/16 - research to date
- n = 05/16 - professional associations
- n = 05/16 - conferences
- n = 03/16 - previous forensic nursing courses already out there
- n = 01/16 - other sources (*journal review, volunteer, military, colleagues*)
- **From Email Survey (n=17)**
- n = 15/17 - Education - took forensic courses
- n = 12/17 - Education - took forensic nursing course

*Q7 Titles of Courses/ Units of Study*

Many variables (Quantitative)

- (88 + courses) Titles of Courses and Units of Study?
- n = 8/17 offered an Introductory Course
- n = 2/17 offered both Forensic Science & Forensic Behavioral Sciences
- n = 7/17 offered only Forensic Science courses
- n = 1/17 offered only Forensic Behavioral Sciences courses
- n = 7/17 of the course titles it was difficult to determine
- n = 11/17 Nursing was in the title of the program or course
- Concepts to Include (See Chapter VII Taxonomy of Forensic Concepts to include]

## Appendix E3 (cont.)

Summary of Analysis of Qualitative Interview Responses

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*Q8. Most Satisfying (Positive Influence)*

- Student enthusiasm, awareness, high enrollment, roles/careers
- Educator enthusiasm, forensic educator role
- Forensic specialty acceptance by nursing
- Other discipline acceptance (medicine first & last)
- Patient improved care, court outcomes

*Least Satisfying (Negative Influence)*

- Students lack of enthusiasm, curiosity, sensationalism, victimization disclosure
- Educators lack of resources, lack of admin support, high workload, travel
- Forensic specialty lack of acceptance by nursing, lack of role understanding
- Resistance from physicians

*Q9. Organizations Foster (Positive Influence)*

- Governments grants, policies, funded needed programs
- Forensic systems/ services partnerships and agreements
- Health Care System provided funding, training, tuition, work replacement
- Publications/Journals provided widespread dissemination (JEN, JPN, JFN)
- Professional Associations fostered (IAFN\*, ENA, ANA)
- Community woman's groups' & agencies fostered
- Other Forensic Disciplines support for scope of role
- Nursing discipline – forensic nurses leaders, pioneers in professional associations

*Organizations Not Foster (Negative Influence)*

- Denial of Governments grants/funding
- Forensic Systems/ Services were skeptical
- Health Care System denied funding, training, tuition, shift replacement,
- Employer discourage graduate education as takes away from the bedside
- Publications/journals could have done more
- Professional Associations - many nurses do not participate
- Community skepticism
- Other Forensic Disciplines Barrier to scope of role
- Nursing Discipline - Need for leadership

## Appendix E3 (cont.)

Summary of Analysis of Qualitative Interview Responses

---

*Q10. Educational Institutions Supportive (Positive Influence)*

- Forensic focus market niche
- Forensic as a societal/educational trend
- Administrators supportive
- Curriculum electives
- Advantages of online education
- Student demand
- Passion & drive of individual educators\*

*Educational Institutions Non Supportive (Negative Influence)*

- Resistance & skepticism from universities, administration and physicians
- Attitude that trend & popularity will not last
- Online education not supported
- No room in curriculum
- Nursing forensic role misunderstood
- Housed in forensic science not in nursing
- Nursing shortage
- Shortage of skilled forensic faculty

*Q11. Influencing Factors (Positive and Negative Influences)**Societal Facilitating factors? (Positive Influence)*

- Awareness in society
- Forensic trend
- Societal need for role & education
- Acceptance of nursing

*Societal Impeding factors? (Negative Influence)*

- Perception of increased violence
- Bandwagon effect
- Fascination with crime
- Physician role sanctioned

## Appendix E3 (cont.)

Summary of Analysis of Qualitative Interview Responses

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*Media Facilitating factors? (Positive Influence)*

- Public education by the media /high profile cases
- Forensic TV shows (CSI)
- Media help in missing children campaigns
- Increased interest in forensic role

*Media Impeding factors? (Negative Influence)*

- Sensationalism, forensic roles misrepresented, nurses role hidden, exploitation of victims

*Economic Facilitating factors? (Positive Influence)*

- Gov't funding/grants
- Cost recovery due to popularity & high enrollment

*Economic Impeding factors? (Negative Influence)*

- Inadequate role compensation
- Cost of technology
- Lack of program funding
- More research needed for cost effectiveness

*Technology Facilitating factors? (Positive Influence)*

- Advanced technology /DNA
- DNA databases
- Online education

*Technology Impeding factors? (Negative Influence)*

- Person in trauma is lost in the technology
- CSI Phenomenon/CSI effect
- New skills needed to keep up

*Political Facilitating factors? (Positive Influence)*

- Legislation/policy changes
- Specialty status
- Emerging social priorities

*Political Impeding factors? (Negative Influence)*

- Generalist vs. specialist education
- Societal understanding of traditional roles
- Uphill battles for change

## Appendix E3 (cont.)

## Summary of Analysis of Qualitative Interview Responses

*Q12. Historical- -Why courses were developed? (Positive Influence)*

- Need in society for medico-legal role for nursing
- Social awareness, social movements, emerging social priorities
- Infrastructures in place (all factors below)
- Qualified faculty -passionate person/key driver/educator
- Administration - supportive
- Resources- gov't grants/program funding
- Curriculums – flexible, elective options
- Market demand
- Media – promotion/ public education by media
- Forensic trend, market niche/forensic focus
- Role compensation - comparable
- Traditional roles in society - changing
- Physicians & other forensic disciplines – supported
- Technology advancements
- Professional associations – fostered (\*IAFN, ANA, ENA)
- Nursing discipline - acceptance

*Historical- -Why courses not developed sooner? (Negative Influence)*

- Need in society for medico-legal role for nursing - not understood
- Prior to social movements - vulnerable populations not valued
- Infrastructures not in place - all factors below  
(no specialty educational programs in nursing till 1980s)
- Few qualified educators with desire to develop programs
- Administration - not supportive
- Resources and funding - denied
- Curriculum – no Room, No elective options
- Market flat - Jobs not there
- Media - nursing role hidden/misrepresented, sensationalism
- Forensic trend- will not last
- Role compensation – inadequate
- Traditional roles in society- sanctioned
- Physicians and other forensic disciplines – resistive, non supportive
- Technology - high costs, some struggle to keep up
- Professional associations – could have done more
- Nursing discipline – non accepting

*Q13. Sustainability factors? (Positive Influence)*

- Key driver, significant person with passion and a mission
- Administrative support
- Resources of online or highly populated location, qualified faculty
- Partnerships and/or affiliations

*Non Sustainability factors? (Negative Influence)*

- Lack of qualified faculty (one person programs)
- Lack of administrative support
- Lack of resources, low funding
- Low compensation for SANE trainers and examiners

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(Summary from the Qualitative Interview, 2008)



## APPENDIX E4

Table E1 Database of Key Words A-Z

Table E1	Database of Key Words A-Z	
A (26)	C (cont.)	C (cont.)
Abuse /neglect	Certificate	Court/Court Testimony*
Academia	Chain of Custody	Create
Acceptance	Change	Credibility
Accountable	Child abuse	Crime
Accreditations	Child Infant	Crime Scene
Acknowledge	Circumstances	Criminalist
Adaptation Model	Client	CSI /CSI Effect
Addictions	Clinical	Criminal
Administration/Administrator	Clinical Forensic Nursing	Criminal Justice System
Advanced/Advancing	Clinical Nurse Expert	Criminology
Advanced Nursing Practice	Clinical Setting	Crisis/Event
Advancing Humanity	Collaborate*	Crown
Advocate/Advocacy*	Colleagues	Culture
Affiliation	Collide	Curiosity
Analysis	Combination	Current
Application	Community*	Curriculum
Approach	Competencies	Crisis/event
Articulate	Component	Custody
Assessment	Complex	
Assignments	Compréhensive	D (18)
Assisted Suicide	Concept*	Death Investigator
Associated	Conceptual	Defense
Associations*	Framework/Conceptualized*	Definition*
Attitude	Concern	Defining Moment
Attributes/characteristics	Conference	<u>Dichotomy*</u>
Awareness*	Confidence	Difference
	Confidentiality	Different*
B (08)	Connection	Different from the US
Background	Consent	Directors
Barriers –Opposition*	Construct	Disabilities
Base/Basic	Consultants	Discovery
Battered Women’s Program	Consumer	<u>Discipline*</u>
Behaviour	Content (see Concepts)	Diversity
Behavioural Sciences	Continuing Education	DNA
Blend	Control	Documentation
Boundaries	Co-opted	Domain
	Core*	Domestic Violence
C (61)	Coroner	<u>Driver*</u>
Care/Caring*	Corrections/ Correctional	
Career /Opportunities	Counseling	
Case	Course Content (see Concepts)	

## APPENDIX E4 (cont.)

Table E1 (cont.)	Key Words A-Z (cont.)	
E (27)	F (57)	F (cont.)
Economic*	Forensic Experts	Framework
Educational Background	Forensic Field	Fundamental
Educational Level	Forensic Focus	
Elder Abuse	Forensic Health Issues	G (04)
Elective	Forensic Identity (see Identity)	Generalist
Embedded	Forensic Issues	Goal
Employment	Forensic Labels	Government
Empower	Forensic Medicine	Groups
Emergency	Forensic Mental Health	
Emerging	Forensic Mental Health Nursing	H (09)
Enhancing	<u>Forensic Nurse*</u>	Harm
Enrollment/ applicants	Forensic Nurse Death	Harm Reduction
Enthusiasm/ Excited*	Investigators	Health
Envelope	Forensic Nurse Educators	Health Care
Environment	Forensic Nursing	Health Promotion
Equal/Equality	Forensic Nursing Clinical Experts	History
Essence	Forensic Nursing Education	Holism/Holistic
Essential	Course/Program	Humanistic
Ethics	Forensic Nursing Educational	Humanity
Evidence Collection*	Level of Course/Program	
Evolved	Forensic Nursing Identity	I (27)
Expanded/Expanding*	Forensic Nursing Practice	Identification/Identify
Experience	Forensic Nursing Role	Identity
Expert Witness*	Forensic Nursing Title	Image
Expertise	Forensic Patients	Incarcerate
Extra	Forensic Populations	Incorporate
Extremes	Forensic Principles	Independent Practice
	Forensic Provider	Individual
F (57)	Forensic Psych Course	Initiate
Facilitator	Forensic Psychiatry	Injury
Family	Forensic Psychiatric Nursing	Institutions
Family Violence	Forensic Psychology	Integrate
Fear	Forensic Role	Integration
Field	Forensic Science	Intent
Fit	Forensic Services	Interaction
Focus	Forensic Settings	<u>Interdisciplinary*</u>
<u>Forensic*</u> (Adjective Alpha	Forensic Specialties	Interest
order)	Forensic System	Interesting
Forensic Area	Forensic Teams	Interfacing
Forensic Assessment	Forensic Toxicology	International
<u>Forensic Behavioural Sciences*</u>	Forensic Training	International Association of
Forensic Course Content	Forensics (Noun)*	Forensic Nurses (IAFN)
Forensic Epidemiology	Formative	Internet
Forensic Evidence	Foundations	

## APPENDIX E4 (cont.)

Table E1 (cont.)	Key Words A-Z (cont.)	
(I) (cont.)	N (22)	P (cont.)
Interpretation	Needs	Persistence
Intersection/ Intersectoral	Needs Assessment	Person
Intervention	Negligence	Pervasive
Interview	Network/ Networking	Phenomenology
Investigation	Nurse	Philosophy
Issues	Nurse/Lawyer	Photography
	Nurse Practitioner	Physical
J (03)	Nursing	Physicians
Job Market	Nursing Base	Physiological
Judicial System	Nursing Care	Physiology
Justice	Nursing Education	Police
	Nursing Educators	Policy
K (02)	Nursing Focus	Political
Key	Nursing Issue(s)	Popular
<u>Knowledge*</u>	Nursing Knowledge	Population
	Nursing Literature	Population Health.
L (07)	Nursing Paradigm	Power
Labels/Language	Nursing Practice	Practice
<u>Law/legal*</u>	Nursing Process	Practice Issues
Law Enforcement	Nursing Program	Practice Standards
Leadership	Nursing Progress	Prevention
Legal Nurse Consulting	Nursing Shortage	Principles
Liability		Prison
Literature	O (06)	Process
	Objectivity	Professional
M (14)	Offend/Offenses	Professional Associations*
Malpractice	Offender	Professional Boundaries
Manipulation	Online Education	Promote
Market/Marketing*	Opportunity	Prosecution
Meaning	Organization	Protection/Safety
Media*		Psychiatric Evaluation
Medical	P (46)	Psychiatric Nursing Program
Medication	Paradigm	Psychological
Mental Health	Participate	Psychosocial
Mentoring	Particular/ specific	Public
Military	Partnership	Public Health
Mission	<u>Passion*</u>	Publications
Misunderstood/ Misrepresented	Patient	
<u>Multidisciplinary*</u>	Patient Rights	Q (02)
Multisectoral collaboration	Patient Safety	Quality Control
	Perpetrators	Question

## APPENDIX E4 (cont.)

Table E1(cont.)

## Key Words A-Z (cont.)

<b>R (11)</b>	<b>S (cont.)</b>	<b>U (04)</b>
Realm	Social Service Mission	Umbrella
Recognize	Social Work	Understanding/ Misunderstanding
Recruiting	Sociology	<u>Unique*</u>
Relationship	Specialty/specialized	Uniting
Research	Specific	
Resistance	Standards of Practice (see	<b>V (11)</b>
Resources	Practice Standards)	Validity
Responsibility	Status	Value
Rights	Strategy	Vast/Scope
Risk Management	Stress Framework	Victim*
Role*	Structure	Victimology
	Struggle	Victimization
<b>S (38)</b>	Student	Victimology
Safe/Safety	Subspecialty	Violence*
Satisfying	Support	voir dire
Science	Survivors	Volunteer
Scope	Suspects	Vulnerable Populations
Security	Sustainable	
Sensationalism	Synthesize	<b>W (05)</b>
Servant	System	Wounding
Serve		Women
Services	<b>T (10)</b>	Workshops
Setting	Tasks	Wrongfully Accused
Sexual Assault	Teaching	Why courses not sooner?
Sexual assault course outline	Technical Skills	
Sexual Assault Nurse Examiners	Technology*	<b>X (00)</b>
SANE	Theoretical*	
Shared	Therapeutic	<b>Y (01)</b>
Situation	Title of the Program	Young Offender
Skills	Trauma	
Slippery slope	Treatment	<b>Z (00)</b>
Significant Person/Driver	Truth	
Social /Society		

Total = 430 Key Words

Total = 334 pages of data examples of Key Words

## APPENDIX E5

Table E2 Database of Initial Themes

Table: E2 Database of Initial Themes A-Z		
<b>A (8)</b> Acceptance Administration/ Administrators <u>Advanced Nursing Practice*</u> Advocate Affiliation/Collaborate/Partner Associations Attitude Awareness	<b>D (10)</b> Definition Defining Moment/ DNA ( <u>deoxyribonucleic acid</u> )* Dichotomy Differences Differences with the US Directors/ Coordinators (leaders) Discipline Diversity Driver	<b>F(cont.)</b> Forensic Science Forensic Setting Forensics (noun) Foster Foundations Fundamental
<b>B (3)</b> Barrier Basic Behavioural Sciences	<b>E (13)</b> Economic Education Educational Level Educational Institution Barrier Educators Individuals Electives Enrollment Enthusiasm/ Excitement Essence Ethics Evolved New Area Expanded Role Experts	<b>G (00)</b>  <b>H (04)</b> Health History Holism/ Holistic Humanity
<b>C (21)</b> Care/Caring Career Opportunities Client Clinical Experience Clinical forensic nursing practice Clinical Nurse Specialist Collaborate/ Affiliation Community Concepts Conceptualization Confidence Consistency Consumer Demand Continuing Education Core Court Testimony Create Credibility CSI/ CSI Effect Current Curriculum	<b>F (18)</b> Fear Focus (Broad, General) Forensic Course Content Forensic Issues Forensics Living Understanding Forensic Nursing Clinical Experts Forensic Nursing Educators Forensic Nursing Generalist program Forensic Nursing Identity Labels Forensic Nursing is: [#1. Forensic Principles Forensic Provider	<b>I (10)</b> Identity/Image Independent practice Individual Injury Interaction Interface International IAFN Intersection Issue
		<b>J (01)</b> Job Market
		<b>K (01)</b> Knowledge
		<b>L (05)</b> Labels/ Language <u>Law/Legal*</u> Leaders and Experts Liaison Literature

## APPENDIX E5 (cont.)

Table: E2 (cont.)	Initial Themes A-Z (cont.)	
M (04) Market/Marking Media Misunderstood/Misinterpret <u>Multidisciplinary*</u>	Q (02) Quality Control Question Difficulty  R (04) Recognition Research Resources Role  S (16) Satisfying – Most Satisfying - Least Sensationalism Service Significant Person Skills Social/Society Specialty/ Specialization Stress Framework Struggle Student Support Survivor Sustainability – Factors Sustainability barriers Systems/Services  T (06) Technical Skills Technology Theoretical Titles of Courses Title of the Program Travel	U (02) Understanding / Misunderstanding <u>Unique*</u>  V (05) Value/Valued Victim Victimization Volume of Content Volunteer  W (03) work with Workshop Why Courses /How Came about?  X (00)  Y (00)  Z (00)
N (06) Needed Nursing Nursing Education Nursing Literature Nursing Paradigm Nursing Process  O (06) Objectivity Offender Online education Organizations Foster* Organizations NOT Foster* Others People Forensic Nurses  P (13) Participation <u>Passionate Individual*</u> Patient Patient Protection/Safety Perpetrators Person Individual Philosophy Physicians Political/Policy Practice Standards Professional Associations Public Health Publications		

Total = 161 Initial Themes

Total = 177 pages of Data Examples

*Vita--Brief Biography of the Doctoral Candidate*

Arlene Kent-Wilkinson is currently an Assistant Professor for the College of Nursing at the University of Saskatchewan. She has over 30 years of clinical experience in emergency, addictions, correctional, and forensic psychiatric nursing. She began writing and teaching classroom forensic nursing courses in 1995, and online forensic nursing courses in 1997. She is the recipient of the Pioneer Award in Forensic Nursing in 1997 from the International Association of Forensic Nurses and the Provincial Education Excellence Award in 2002 from the Alberta Association of Registered Nurses.